Plan Document
and
Summary Plan Description

Grace Cottage

Flexible Benefits Plan – General Purpose Medical Care Reimbursement Account/Dependent Care Reimbursement Account

Group No: 006B16

Effective: January 1, 2021

INDEX

I. ESTABLISHMENT OF PLAN

THIS INSTRUMENT established by Grace Cottage (hereinafter the "Employer") on this 1st day of January, 2021 sets forth the Grace Cottage Flexible Benefits Plan effective as of January 1, 2021.

A. Establishment of Plan

Grace Cottage (the "Employer") hereby establishes the Grace Cottage Flexible Benefits Plan (the "Plan") with a Medical Care Reimbursement Account (MCRA) and Dependent Care Reimbursement Account (DCRA) under this Plan for the exclusive benefit of its Employees. The Plan is intended to qualify as a Medical Reimbursement Plan under §105(b) of the Internal Revenue Code ("the Code") and as a Dependent Care Assistance Program under §129 of the Code. The purpose of the Plan is to enable Participants to elect to receive reimbursements for Qualifying Medical Care Expenses and Qualifying Dependent Care Expenses in lieu of compensation, which payments are excludable from the Participant's gross income under §§106 and 129 of the Code.

B. Effective Date

The Plan as described herein is effective as of January 1, 2021.

The Plan is subject to all of the conditions and provisions set forth in this document and subsequent amendments which are made a part of this Plan.

II. GENERAL INFORMATION

Plan Name:	Grace Cottage Flexible Benefits Plan with a Medical Care Reimbursement Account (MCRA) and Dependent Care Reimbursement Account (DCRA) (the "Plan")
Type of Plan:	Welfare plan providing medical care and dependent care expense reimbursements
Effective Date:	January 1, 2021
Employer/Plan Sponsor:	Carlos G. Otis Health Care Center, Inc. d/b/a Grace Cottage (the "Employer") 185 Grafton Road Townsend, VT 05353 (802) 365-7357
ERISA Plan Number:	501
Employer Identification Number:	03-0177161
Group Number:	006B16
Plan Administrator:	Employer (see above)
Claims Administrator:	Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 www.healthplansinc.com (877) 734-7004
COBRA Administrator:	Please refer to your Human Resources Department for additional information
Agent for Service of Legal Process:	Employer (see above)
Plan Cost:	Contributory
ERISA Plan Year Ends:	December 31st
Fiscal Year Ends:	September 30th

III. DEFINITIONS

The following words and phrases will have the following meanings when used in the Plan, unless a different meaning is plainly required by the context.

Account(s) – a Medical Care Reimbursement Account (MCRA) and/or Dependent Care Reimbursement Account (DCRA)

Carryover - the amount of an unused MCRA balance that an MCRA Participant may apply to Qualifying Medical Care Expenses incurred in subsequent Plan Years as specified in *Medical Care Reimbursement Account* section of this Plan; Dependent Care Reimbursement Accounts (DCRAs) do not have Carryover

Claim Administrator – the person, persons, entity or entities appointed by the Employer, who shall process all or a designated portion of the claims under this Plan in accordance with the Plan's terms

Code – the Internal Revenue Code of 1986 as now in effect and as may be amended, together with any governing regulations

Covered Compensation – a Participant's earned income, salaries, wages, fees, commissions, overtime bonuses, tips and all other earnings of a Participant reportable on Form W-2 for the Plan Year, including amounts contributed by a Participant to the Plan, but excluding all other contributions to any other Plan sponsored by the Employer and all other forms of compensation

Dependent Care Reimbursement Account ("DCRA") – an Account established to help Participants pay eligible dependent care expense with before-tax dollars

Elective Contributions – the amount of compensation reduction a Participant elects to apply to his or her MCRA and/or DCRA; it is intended that such amounts shall, for tax purposes (including §125 of the Code), constitute an Employer Contribution

Eligible Employee – an Employee who meets the eligibility requirements under *Eligibility, Enrollment and Participation* of this Plan.

Employee – any individual who is considered to be in an employer-employee relationship with the Employer for purposes of federal withholding taxes

ERISA – Employee Retirement Income Security Act of 1974, as amended

Highly Compensated Employee – one of the five (5) highest paid officers, a shareholder who owns (with the application of §318) more than ten (10) percent in value of the stock of the employer, or among the highest paid twenty-five (25) percent of all employees (other than employees excluded under §105(h)(3)(b)

HIPAA – the Health Insurance Portability and Accountability Act of 1996, as amended from time to time

Key Employee – an Employee who is a five (5) percent shareholder, or an officer with income above a certain threshold as defined as such in §4l6(i)(l) of the Code, or a one percent shareholder with income above certain thresholds as defined in §416(j)(l)

Medical Care Reimbursement Account ("MCRA") – an Account established under the terms of this Plan to enable a Participant to pay eligible medical expenses with before-tax dollars

Open Enrollment Period – the period of time during which Participants and Eligible Employees may elect to make Elective Contributions under the Plan to take effect on the first day of the following Plan Year

Participant – an Eligible Employee who has elected to make Elective Contributions to a MCRA and DCRA under this Plan

Plan Administrator – the Employer or its successor or successors, which shall have authority to administer the Plan as provided in this document under *Plan Administration*

Plan Year – the twelve (12) month period ending on the date shown in the *General Information* section

Qualifying Change in Status – events which allow a Participant or Eligible Employee to change his or her election with respect to participation and Elective Contributions under this Plan during a Plan Year as described under *Eligibility, Enrollment and Participation* and in accordance with IRS and HIPAA regulations

Qualifying Dependent Care Expenses – expenses incurred by a Participant which (1) are paid or incurred for the care of a Dependent of the Participant or for related household services, (2) are paid or incurred to a Dependent Care Service Provider, and (3) are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant; Dependent Care Expenses shall not include expenses paid or incurred for services rendered outside the Participant's household for the care of a Dependent unless the Dependent is described in the Definition of Dependent or regularly spends at least eight (8) hours a day in the Participant's household; Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered

Qualifying Dependent Care Service Provider – a person or entity identified in the Internal Revenue Code as qualified to receive payments for dependent care which may be reimbursed through a Dependent Care Reimbursement Account; please refer to *Qualifying Dependent Care Service Providers*, for examples

Qualifying Event – an event that causes a loss of eligibility to participate in a Medical Care Reimbursement Account (MCRA) (see *COBRA Coverage*)

Qualifying Medical Care Expenses – expenses incurred by a Participant, or by the spouse or other federal tax dependent of a Participant, or by the Participant's child through the end of the taxable year in which the child reaches age 26, for medical care as defined in §213(d) of the Code, except that for the purposes of this Plan, Qualifying Medical Care Expenses do not include payment of premiums under a health insurance plan or expenses for cosmetic surgery as defined by Code §2l3(d)(9)

IV. HOW THE PLAN WORKS

Under this Plan, Participants agree to reduce their compensation in exchange for being reimbursed for eligible medical and dependent care expenses on a before-tax basis, through a Medical Care Reimbursement Account ("MCRA") and/or Dependent Care Reimbursement Account ("DCRA"). Any election to receive reimbursement for Qualifying Medical Care Expenses or Qualifying Dependent Care Expenses is irrevocable for the duration of the Plan Year except under the special circumstances described under *Changing an Election* in *Eligibility, Enrollment, and Participation*. Under the rules imposed by the Internal Revenue Code, Participants enrolled in the MCRA may carry over a maximum of $550 of unused MCRA balances from one Plan Year to the following Plan Year. Any unused prior Plan Year MCRA balance not eligible to be carried over for reimbursement of Qualifying Medical Care Expenses or any unused DCRA balance for Qualifying Dependent Care Expenses which are not claimed by the deadlines described under Claims Reimbursement in *Medical Care Reimbursement Account* and *Dependent Care Reimbursement Account* sections must be forfeited by the Participant and may be used by the Plan Administrator to offset Plan expenses.

A. Compensation Reduction Agreement

Under this Plan, Participants enter into compensation reduction agreements with the Plan Administrator, under which compensation otherwise payable to each Participant will be contributed to each Participant's MCRA and DCRA in the amount(s) specified as the Participant's Elective Contributions under the agreement.

The total amount of a Participant's Elective Contributions are divided over the number of pay periods remaining in the Plan Year and will be deposited in equal amounts to his or her MCRA and/or DCRA. There are certain limits on contributions to a Participant's MCRA and/or DCRA that are described in *Medical Care Reimbursement Account* and *Dependent Care Reimbursement Account* sections.

B. Reducing Taxable Income

It is intended that the reduction in each Participant's otherwise payable compensation designated as Elective Contributions will be eligible for exclusion from the Participant's adjusted gross income as provided in §§106 and/or 129 of the Internal Revenue Code. This means that Participants will pay less in federal, and in many cases, Social Security (FICA) and state income taxes (except in those states where before-tax reduction is not permitted). Participation in this Plan may slightly reduce Participants' Social Security benefits as Elective Contributions are not subject to either Participant or Employer contributions to Social Security taxes.

C. Maximum Reimbursements

The maximum amount which a Participant may receive under this Plan in the form of payments or reimbursements for Qualifying Medical Care Expenses and Qualifying Dependent Care Expenses incurred in any Plan Year will be regulated according to the applicable sections of the Code, including §105 and §129. The Plan Administrator shall reduce or adjust such contributions under a Participant's MCRA and/or DCRA as shall be necessary to assure that, in the judgment of the Plan Administrator, participation in this Plan will not discriminate in favor of Highly Compensated or Key Employees.

V. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

A. Eligibility

Employees who work on a regular full-time or part-time basis may participate in this Plan on the first day of the month following one (1) month of continuous employment. For the purposes of this Plan, an Employee is considered full time if he or she is regularly scheduled to work twenty (20) or more hours per week.

Additional eligibility requirements:

(1) Medical Care Reimbursement Account ("MCRA")

Under Internal Revenue Code rules, Participants in High-Deductible Health Plans with Health Savings Accounts or dependents eligible for benefits under a Health Savings Account (for example, a spouse's Health Savings Account) are not eligible to participate in or receive benefits from a general purpose MCRA. However, such Participants may participate in a Limited Purpose Medical Care Reimbursement Account ("Limited Purpose MCRA").

(2) Dependent Care Reimbursement Account ("DCRA")

Under Internal Revenue Code rules, a Participant in a DCRA must be an Eligible Employee who falls into one of the following categories:

(a) Married to a spouse who is employed;

(b) Married to a spouse who is disabled;

(c) Married to a spouse who is a full time student; or

(d) Single.

Note: Under certain limited circumstances, a married Participant who does not live with his or her spouse may qualify as "single" for the purposes of this provision. Employees should consult with their tax advisor or the IRS to verify their status for the purposes of this exception.

It is the participating Employee's responsibility to verify that he or she satisfies the additional eligibility requirements above.

B. Enrollment

An Eligible Employee may enroll to participate in this Plan, provided any required enrollment forms are completed and submitted within the applicable enrollment periods described below.

Enrollment due to:	Enrollment period:	Reimbursement available for expenses incurred on or after:	
		DCRA	MCRA
Initial eligibility	The thirty-one (31) day period that begins on the first of the month following the date of hire as a full-time Employee	The first day of the first pay period coinciding with or next following the date the enrollment form is submitted	The date the Employee becomes enrolled in the MCRA
Open Enrollment Period	Annually as specified by the Plan Administrator	The first day of the Plan Year following the Open Enrollment Period	
Qualifying Change in Status	The thirty (30) day period that begins on the date of the Qualifying Change in Status	The first day of the first pay period coinciding with or next following the date the enrollment form is submitted	The date the Employee becomes enrolled in the MCRA

Annual Enrollment Required: To continue participation in this Plan, Eligible Employees must submit new enrollment forms during the annual open enrollment period indicating the amounts of their Elective Contributions for the MCRA and/or DCRA for the subsequent Plan Year. In the absence of a new election for the subsequent Plan Year, participation ends automatically on the last day of the current Plan Year.

(1) Elective Contributions

To enroll in the Plan, a Participant must designate the amount(s) of his or her Elective Contributions to the MCRA and/or DCRA on his or her enrollment form. In general, the amount of Elective Contributions is an irrevocable election unless the Participant has a Qualifying Change in Status as described under *Changing an Election*, below.

NOTE: The Medical Care and Dependent Care Reimbursement Accounts are separate options under this Plan. Elective Contributions may not be transferred between these Accounts.

- Estimating Elective Contribution(s): For the purposes of estimating Elective Contributions to the MCRA and/or DCRA, Participants should keep in mind that any unused prior Plan Year MCRA balance up to $550 may still be carried over and available to reimburse Qualifying Medical Care Expenses incurred in subsequent Plan Years. ***Any other amounts remaining in the MCRA and/or DCRA after the claim filing deadlines will be forfeited.***

MCRA Carryovers from the prior Plan Year do not reduce the amount of the Elective Contributions that a Participant is eligible to contribute to a current Plan Year MCRA.

Please refer to *Medical Care Reimbursement Account* and *Dependent Care Reimbursement Account* sections for the applicable contribution limits and information about eligible expenses reimbursable through the general purpose MCRA and/or DCRA.

- Non-discrimination: In the event that the Plan Administrator determines that the amount of a Participant's Elective Contribution exceeds the limits under IRS rules, the Participant's election to participate and make Elective Contributions may in the discretion of the Plan Administrator be treated as void or as an election to have withheld the maximum amount permissible under the applicable limitation.

Use it or lose it: Plan Participants should carefully estimate the amount of qualifying expenses likely to be incurred during the Plan Year. Under IRS rules, any amount not used to pay qualifying expenses will be forfeited by the Plan Participant, except for MCRA Carryovers described under *Medical Care Reimbursement Account*. Please refer to Carryover of Unused Account Balance and Forfeiture of Unused Account Balance under *Medical Care Reimbursement Account* for a more detailed explanation about these provisions.

(2) Changing an Election

In general, Participants and Eligible Employees may not change or revoke their elections regarding Elective Contributions to the MCRA and/or DCRA during a Plan Year. However, if a Participant or Eligible Employee experiences a Qualifying Change in Status during the Plan Year, he or she may also be eligible to make a corresponding change to their Elective Contributions.

For the purposes of this Plan, Qualifying Changes in Status include:

(a) Marriage, divorce, legal separation or annulment

(b) Birth, adoption or placement for adoption of a dependent child

(c) Death of a spouse or dependent

(d) Commencement of or return from unpaid leave

(e) Loss of dependent status or eligibility under the Plan as a dependent

(f) A change in employment status for the Participant, spouse or dependent which causes the individual to become eligible or cease to be eligible under the respective employer's employee benefit plan

(g) Enrollment of the Employee, spouse or dependent under the Employer's group health plan as a special enrollee in accordance with HIPAA

(h) Commencement of an Employee's leave under the Family and Medical Leave Act (FMLA)

(i) Any other material and unforeseen change in circumstances, outside the control of the Employee, which would be deemed a Qualifying Change in Status under IRS regulations.

In addition to the events listed above, the following events are also considered Qualifying Changes in Status with regard to the DCRA:

(a) Change in the number of Qualifying Dependents

(b) Change in Qualifying Dependent Care Service Provider which results in a change in the cost of Qualified Dependent Care Expenses

(c) Change in the number of hours worked by a Qualifying Dependent Care Service Provider

(d) Increase in the rate charged by a Qualifying Dependent Care Service Provider who is not a relative of the Participant

Any request to change or revoke an election for Elective Contributions under this Plan:

(a) Must be made in writing on the proper forms available from the Claims Administrator within 30 days of the Qualifying Change in Status; and

(b) Must correspond with the Qualifying Change in Status

Examples of elections which correspond with a Qualifying Change in Status:

If a Participant acquires a new dependent, he or she could increase the Elective Contribution to the MCRA, but could not reduce the contribution.

If eligible dependent care costs increase, a Participant could elect to increase Elective Contributions to a DCRA (subject to the limits described in *Dependent Care Reimbursement Account*), but could not change Elective Contributions to an MCRA.

(3) MCRA and DCRA Accounts

The Employer will establish and maintain on its books a MCRA and DCRA for each Plan Year with respect to each Participant. The amount of Elective Contributions for any Plan Year will be subject to the limits described in the *Medical Care Reimbursement Account* and *Dependent Care Reimbursement Account* sections of this Plan. Any applicable MCRA Carryover from the prior Plan Year does not reduce the amount of the Elective Contributions that a Participant is eligible to contribute to a current Plan Year MCRA.

(a) Credits to Accounts

A Participant's MCRA will be credited with the amount of his or her annual Elective Contribution amount, plus any applicable Carryover, on the first day of the Plan Year or, if later, on the date participation begins in the Plan.

If a Participant does not elect to make Elective Contributions to an MCRA for the upcoming Plan Year, any unused prior year MCRA balance up to $550 may still be carried over and available to reimburse Qualifying Medical Care Expenses incurred in subsequent Plan Years.

A Participant's DCRA will be credited each time a Participant is paid compensation by the Employer with an amount equal to the Participant's annual Elective Contributions divided by the remaining pay periods in the Plan Year.

All amounts credited to each MCRA or DCRA are the property of the Employer until paid out as reimbursement of qualifying expenses.

(b) Debits to Accounts

A Participant's MCRA for each Plan Year will be debited from time to time in the amount of any eligible claim for reimbursement, less any amount previously reimbursed from the MCRA, up to the Participant's Elective Contribution for the Plan Year plus any Carryover from the prior Plan Year, if applicable.

A Participant's DCRA will be debited in the amount of any eligible claim for reimbursement, up to the balance in the DCRA as of the date the claim is submitted.

In no case will reimbursement for expenses incurred during a Plan Year exceed the amount of the Participant's Elective Contribution for such Plan Year.

C. Participation

(1) Participation during Periods of Leave

Except as described below, participation ends automatically during periods of unpaid leave and reimbursement is not available under the MCRA or DCRA for expenses incurred during periods of leave.

(a) MCRA

A Participant may continue to participate in the MCRA during an approved FMLA or military leave by making after-tax contributions to the Plan. Alternatively, a Participant may elect to suspend participation during the period of FMLA or military leave. If participation is suspended during the period of leave, participation will automatically resume in the MCRA when the Participant returns for the remainder of the Plan Year in an amount that will result in total Participant contributions that equal the most current Elective Contributions in effect for that Plan Year.

(b) DCRA

Contributions to the DCRA must stop during a period of FMLA. Participation may be resumed upon return from leave, provided the Employee continues to satisfy the eligibility requirements for participation. If a Participant returns in the same Plan Year, the contribution amount per pay period will remain the same unless the Participant is permitted to make a change consistent with the change in status rules on page 8.

(2) Participation upon Reemployment

If a Participant terminates employment, is rehired within 30 days, and is otherwise eligible to participate in this Plan, he or she may resume participation on the terms described under *Enrollment, Initial eligibility*, on the chart at the beginning of this section.

(3) When Participation Ends

Participation in the Plan continues until the earliest of the following dates:

- The date the Participant terminates employment by death, disability, retirement or other separation from service;
- The date the Participant no longer meets the eligibility requirements for participation in the Plan.
- The date the Participant revokes his or her Elective Contributions to the MCRA and/or DCRA following a Qualifying Change in Status, provided that the new election is received by the Plan Administrator within 30 days of the Qualifying Change in Status.
- The last day of the most recent Plan Year for which the Participant has enrolled to make Elective Contributions to this Plan.
- The date on which this Plan terminates.

Participants in the MCRA may elect continuation coverage under COBRA, as described in *COBRA Coverage*.

VI. MEDICAL CARE REIMBURSEMENT ACCOUNT

The Medical Care Reimbursement Account ("MCRA") enables Participants to pay out-of-pocket medical, dental and vision expenses incurred by themselves and their federal tax dependents, or incurred by the Participant's child in any taxable year in which the child has not attained age 27, that are not reimbursable under any other benefit plan with before-tax dollars. The expenses which qualify ("Qualifying Medical Care Expenses") are generally those permitted by §213 of the Internal Revenue Code. The cost of health care coverage, however, is not eligible for reimbursement through a MCRA.

Because the MCRA is a tax-advantaged way to pay for eligible medical expenses, it is strictly regulated by the IRS. Please refer to *Eligibility, Enrollment and Participation* for important information about participating in this Plan.

Use it or lose it: When determining Elective Contributions for the Plan Year, Plan Participants should carefully estimate the amount of qualifying expenses likely to be incurred. Under IRS rules, any amount not used to pay qualifying expenses will be forfeited by the Plan Participant, except for MCRA Carryovers. Please refer to *Carryover of Unused Account Balance* below for a more detailed explanation about this provision.

A. Contribution Limits

Participants may make Elective Contributions to their MCRA as follows:

Minimum Elective Contribution	$240 per Plan Year
Maximum Elective Contribution	$2,750 per Plan Year

B. Claims for Reimbursement

To receive reimbursement for Qualifying Medical Care Expenses under this Plan, a Participant must either:

(1) Use the debit card issued upon commencement of participation, or

(2) Submit a claim for reimbursement on the forms available from the Claims Administrator, and include substantiation of the claim. Substantiation required includes:

(a) Amount, date and nature of the expense, and date and method of payment for the expense with respect to which a benefit is requested as shown on a receipt, statement of account, invoice, cancelled check, together with any additional documentation the Plan Administrator may request;

(b) Name of the person, organization or entity to which the expense was paid;

(c) The name of the person for whom the expense was incurred and, if such person is not a Participant requesting the benefit, the relationship of such person to the Participant; and

(d) Any amount recovered under any insurance arrangement or other plan with respect to the expense as shown on a health plan's Explanation of Benefits form or other similar document.

Any claim for reimbursement under this Plan must be submitted no later than March 31st following the close of the Plan Year for qualifying expenses incurred during the Plan Year. See *Medical Care Reimbursement Account Claim Review Procedures and Statement of ERISA Rights,* for additional important details regarding the claim submission process.

C. Carryover of Unused Account Balance

The amount credited to a Participant's MCRA for any Plan Year may be used only to reimburse the Participant for Qualifying Medical Care Expenses incurred and paid during the Plan Year and only if the Participant submits claims for reimbursement on or before March 31st following the close of the Plan Year. Participants may carry over a maximum of $550 of unused MCRA balances from one Plan Year to the following Plan Year as described below.

- For the first ninety (90) days following the end of the prior Plan Year, claims will be processed in the order they are received, as follows:

- Claims for Qualifying Medical Care Expenses incurred in the current Plan Year will be reimbursed first from the current Plan Year MCRA balance. If a current Plan Year claim exceeds the current Plan Year Elected Contributions, the claim will then be reimbursed from the prior year unused MCRA balance, if any, up to $550.

- Claims for Qualifying Medical Care Expenses incurred in the prior Plan Year will be reimbursed from any remaining prior year unused MCRA balance.

- As of the 91st day following the end of the prior Plan Year, any remaining unused prior year MCRA balance, up to $550, will be added to the remaining available MCRA balance for the current Plan Year. Any unused prior year MCRA balance not eligible to be carried over must be forfeited by the Participant and will be used by the Plan to offset Plan expenses.

- Carryover amounts from a prior Plan Year do not reduce the amount of Elective Contributions that a Participant is eligible to contribute to a current Plan Year MCRA.

- If a Participant does not elect to make Elective Contributions to an MCRA for the upcoming Plan Year, any unused prior year MCRA balance up to $550 may still be carried over and available to reimburse Qualifying Medical Care Expenses incurred in subsequent Plan Years.

The example below illustrates how the Carryover provision works:

Current Plan Year Elective Contribution	$2,500
Qualifying expenses incurred and claimed in current Plan Year	$1,700
Current Plan Year MCRA balance as of December 31st	$ 800
Expenses incurred in current Plan Year and claimed during first 90 days of next Plan Year	$ 200
Remaining unused current year MCRA balance	$ 600
Amount eligible for Carryover (maximum permitted)	$ 550
Next year Elective Contribution	$2,500
Total funds available for qualifying expenses incurred in next Plan Year	**$3,000**
Total amount of current Plan Year Elective Contributions forfeited	**$ 100**

In the absence of an election to make Elective Contributions during the next Plan Year, the total funds available for expenses incurred in the next Plan Year in this example would be $550; the full Carryover available from the current Plan Year. Also, in this example, $100 of the current Plan Year MCRA balance would be forfeited.

D. Qualifying Medical Care Expenses

The following list gives examples of the Qualifying Medical Care Expenses allowed for reimbursement under this MCRA. Please refer to IRS Publication 502 for additional information. Keep in mind, Participants cannot submit expenses which have been reimbursed through another benefit or insurance plan. In addition, expenses for dependents are reimbursable for any person who falls within the definition of dependent as defined in §105(b) of the Code, and any child of the Participant through the end of the taxable year in which the child has reached age 26.

- Abortion
- Acupuncture
- Alcoholism, treatment of
- Ambulance service
- Artificial limb
- Artificial teeth
- Birth control pills
- Braille books and magazines
- Certain capital expenses/home improvements related to medical care
- Chiropractor
- Christian Science practitioner
- Coinsurance and Deductible amounts
- Contact lenses
- Crutches
- Dental treatment
- Drug addiction treatment
- Drugs
- Eyeglasses
- Fertility enhancement
- Medical services provided by medical practitioners
- Menstrual care products
- Nursing home
- Nursing services
- Optometrist
- Organ donors, transplants
- Orthodontic treatment
- Osteopath
- Over-the-Counter drugs
- Oxygen
- Prescription medicines
- Psychiatric care
- Psychoanalysis
- Psychologist
- Smoking cessation programs
- Special telephone for hearing impaired person
- Sterilization
- Surgery
- Television used for audio/visual aid
- Therapy as medical treatment

- Guide dog or specially trained animal
- Hearing aids
- Home health care
- Hospital services
- Laboratory fees
- Laser eye surgery
- Lead-based paint removal
- Learning disability tuition & tutoring
- Legal fees related to medical expenses
- Meals during hospital/health care institution stay
- Medical aids (such as false teeth, hearing aids, orthopedic shoes and elastic hosiery
- Transplants
- Transportation primarily for and essential to medical care
- Tuition for certain special education services
- Vaccines
- Vasectomy
- Vision care (eye exams, eyeglasses, contact lenses, contact lens solutions)
- Weight-loss program at physician's direction
- Wheelchair
- X-rays

Expenses which generally are ***not eligible*** for reimbursement from an MCRA include:

- Expenses for cosmetic procedures and services
- Expenses claimed on a Participant's income tax return
- Expenses not eligible to be claimed as an income tax deduction
- Expenses reimbursed by other sources, such as insurance companies
- Fees for exercise/athletic/health clubs where there is no specific medical reason for membership
- Hair transplants
- Illegal treatments, operations, or drugs
- Insurance premiums
- Nicotine patches and gum
- Postage/handling fees
- Weight reduction programs for general well being

E. COBRA Coverage

If coverage under the MCRA terminates because of a Qualifying Event, Participants and/or covered dependents have the right to continue participation under the Consolidated Omnibus Budget Reconciliation Act (COBRA). An individual who is eligible to participate in COBRA is known as a Qualified Beneficiary.

Continuation under COBRA will be offered to Qualified Beneficiaries for the remainder of the current Plan Year only, and only if the unused MCRA balance as of the date of the Qualifying Event is greater than the cost of COBRA coverage for the remainder of the Plan Year. Otherwise, COBRA coverage is not available for MCRA.

A Qualifying Event is one of the events listed below, when the event causes a loss of eligibility to participate in the Plan. Both the event itself and the resulting loss of benefits must occur in order to create a Qualifying Event under COBRA. The law defines a Qualifying Event as follows:

For the Participant:

- Termination of employment for any reason other than gross misconduct
- Reduction of working hours

For the Participant's spouse and dependent children:

- Death of a Participant
- Termination of Participant's employment for any reason other than gross misconduct
- Reduction of Participant's working hours
- Divorce or legal separation of a Participant and spouse
- Participant's entitlement to Medicare
- Dependent child's loss of dependent status

(1) COBRA Elections

Each Qualified Beneficiary may make a separate election to purchase COBRA coverage when a Qualifying Event occurs. For example, if a Participant terminates employment and does not want to elect COBRA coverage, the Participant's spouse or dependent children may still have the opportunity to do so.

(2) Notice of Events

If coverage under this Plan is lost because of termination of employment, reduction in work hours, death of the Participant or the Participant becoming entitled to Medicare benefits, the Plan Administrator will notify the Participant and his or her dependents of their COBRA rights.

For other Qualifying Events (divorce or legal separation of the Participant and spouse, or the loss of dependent status of a dependent child), the Participant or eligible dependent must contact the Plan Administrator within 60 days after the Qualifying Event occurs. The Plan Administrator will then notify the Participant and his or her dependents of their COBRA rights.

(3) Election of Coverage

A Participant or eligible dependent will have 60 days from the date they are notified of their COBRA rights to make an election to continue coverage under COBRA. If a COBRA election is not made during this 60-day period, continuation of coverage will not be available. Participants may elect coverage on behalf of their spouses, and parents may elect coverage on behalf of their children.

(4) Cost of COBRA Coverage

The cost of continuing coverage under COBRA is 102% (100% of the full cost of the coverage plus a 2% administration fee). The first payment covering the notification and election period is due no later than 45 days after the election is made. Subsequent payments are due on a monthly basis.

(5) Termination of Coverage

COBRA continuation coverage is a temporary continuation of coverage. Because the Plan is an MCRA, this temporary continuation of coverage lasts until the end of the Plan Year in which the Qualifying Event occurs and may not be extended beyond that date.

A Qualified Beneficiary's COBRA coverage will be terminated before the end of the applicable Plan Year if any of the following events occur:

- The Qualified Beneficiary becomes covered under any group health plan, or becomes entitled to Medicare
- The Qualified Beneficiary's contribution is not paid on time or is in an amount that demonstrates a significant shortfall
- This Flexible Benefits Plan is terminated

If a Qualified Beneficiary's COBRA coverage is terminated for any of these reasons, or the Qualified Beneficiary elects to discontinue coverage before the end of the applicable Plan Year, the Qualified Beneficiary will not be eligible to re-elect coverage at a later date.

VII. DEPENDENT CARE REIMBURSEMENT ACCOUNT

The Dependent Care Reimbursement Account ("DCRA") enables Participants to pay qualifying dependent care expenses with before-tax dollars in order to allow them, and if they are married, their spouses to work. The expenses which qualify ("Qualifying Dependent Care Expenses") are generally those permitted by §21 of the Internal Revenue Code.

Because the DCRA is a tax-advantaged way to pay for eligible dependent care expenses, it is strictly regulated by the IRS. Please refer to *Eligibility, Enrollment and Participation* for important information about participating in this Plan.

Use it or lose it: When determining Elective Contributions for the Plan Year, Plan Participants should carefully estimate the amount of qualifying expenses likely to be incurred during the Plan Year. Under IRS rules, any amount not used to pay qualifying expenses will be forfeited by the Plan Participant. Please refer to *Forfeiture of Unused Account Balance* below for a more detailed explanation about this provision.

A. Contribution Limits

The Elective Contribution limits shown below apply to the DCRA.

If the Participant is:	Maximum Annual Elective Contribution is:
Single	$5,000
Married and the spouse's earned income is under $5,000	100% of the spouse's earned income
Married and the spouse's earned income is $5,000 or more	$5,000 (if the spouse also has a DCRA, the combined contribution is limited to $5,000)
Married, but files a separate return	$2,500
Married with a spouse who has no earned income	$5,000 with participation permitted only if the spouse is either a full-time student for at least five months a year or is incapable of self-care. Contributions in these cases are further limited to a maximum of $250 per month for one Qualifying Dependent and $500 per month for two or more Qualifying Dependents.

IMPORTANT: A Participant may not be able to elect the full maximums shown above if the Participant's Covered Compensation (see *Definitions*) is less than $5,000.

Note: Under certain limited circumstances, a married Participant who does not live with his or her spouse may qualify as "single" for the purposes of this provision. Employees should consult with their tax advisor or the IRS to verify their status for the purposes of this exception.

B. Qualifying Dependents

Participants may claim reimbursement for expenses incurred for the care of Qualifying Dependents when the provision of the care enables the Participant, and if married, the Participant's spouse, to be able to work (or be a full-time student). For the purposes of a DCRA, a Qualifying Dependent is:

(1) A child under age 13 who is the Participant's legal dependent; or

(2) A Participant's spouse, dependent parent, or other federal tax dependent (as defined under federal law) who is mentally or physically disabled and is incapable of caring for him or herself, and who spends at least eight hours a day in the Participant's home

C. Qualifying Dependent Care Expenses

Generally, dependent care expenses necessary for gainful employment and which qualify to be used to calculate the dependent tax credit on a federal income tax return are considered eligible for reimbursement through a DCRA if they are paid to a Qualifying Dependent Care Service Provider.

Payments for the following services are examples of Qualifying Expenses:

(1) Child and elder day care center fees,

(2) Nursery school fees,

(3) Pre-kindergarten fees (if the primary purpose is for child care rather than education),

(4) Summer day camp fees, including summer day camps with a focus on a specific topic (e.g., computers, soccer, etc.).

Expenses which ***do not*** qualify for DCRA reimbursement include, but are not limited to:

(1) Overnight summer camp

(2) Summer school

(3) Schools for kindergarten and older grades, except for after-school programs with fees

(4) Boarding schools, except for expenses that are not for educational expenses

(5) Clothing, entertainment and food

D. Qualifying Dependent Care Service Providers

Fees for the services listed above are eligible for reimbursement ***only*** when they are paid to Qualifying Dependent Care Service Providers, as listed below.

(1) Schools, camps or child day care centers that comply with state and local laws, provide care for seven or more children, and receive a fee for services

(2) Dependent day (not residential) care centers for dependent adults that comply with state and local laws

(3) Individuals, excluding the Participant's spouse, dependents and children under age 19, who provide care in or outside the home

Please refer to IRS Publication 503 for additional important information about Qualifying Dependent Care Expenses and providers.

E. Dependent Care Tax Credit

A Participant may find that claiming the dependent care tax credit on his or her annual income tax return may be a more tax-effective way to pay dependent care expenses than participating in this Plan with a DCRA. Expenses that are reimbursed through a DCRA may not be claimed for the dependent care tax credit, and expenses claimed for the tax credit may not be reimbursed through a DCRA.

For families with incomes below certain limits as determined by the Internal Revenue Code, the federal dependent care tax credit varies, gradually decreasing as family income increases, up to a maximum credit as adjusted from time to time. Therefore, whether the DCRA or the federal dependent tax credit is best will depend on the Participant's income in any given year. Eligible Employees should review IRS Publications 503 and 2441 or consult with their tax advisors for more information about the dependent care tax credit before they enroll to make Elective Contributions to a DCRA.

F. Claims for Reimbursement

To receive reimbursement for Qualifying Dependent Care Expenses under this Plan, a Participant must either:

(1) Use the debit card issued upon commencement of participation, or

(2) Submit a claim for reimbursement on the forms available from the Claims Administrator, and include substantiation of the claim. Substantiation required includes:

(a) Amount, date and nature of the expense, and date and method of payment for the expense with respect to which a benefit is requested as shown on a receipt, statement of account, invoice, cancelled check, together with any additional documentation the Plan Administrator may request;

(b) Name and tax identification number (TIN) or Social Security Number of the person, organization or entity to which the expense was paid;

(c) The name of the person for whom the expense was incurred and the relationship of such person to the Participant.

All initial claims for qualifying expenses incurred during the Plan Year must be submitted by March 31st following the end of the Plan Year in which they were incurred.

G. Forfeiture of Unused Account Balance

The amount credited to a Participant's DCRA for any Plan Year shall be used only to reimburse the Participant for Qualifying Expenses incurred and paid during the Plan Year, and only if the Participant submits claims for reimbursement on or before March 31st following the close of the Plan Year. Any remaining balance in the Participant's DCRA will be forfeited by the Participant and may be used to offset Plan administrative expenses.

VIII. MEDICAL CARE REIMBURSEMENT ACCOUNT HIPAA PRIVACY AND SECURITY PROVISIONS

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal law that governs the use and disclosure of protected health information ("PHI") by group health plans and provides rights to Participants with respect to their PHI.

There are three (3) circumstances under which the Plan may disclose a Participant's PHI to the Plan Sponsor.

First, the Plan may inform the Plan Sponsor whether a Participant is enrolled in the Plan.

Second, the Plan may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims experienced by Participants and may identify the Participant.

Third, the Plan may disclose PHI to the Plan Sponsor for Plan administrative purposes. This is because Employees of the Plan Sponsor perform many of the administrative functions necessary for the management and operation of the Plan.

In order for the Plan Sponsor to receive and use PHI, the Plan Sponsor has certified to the Plan that the Plan Sponsor agrees to:

(1) Only use or disclose PHI for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. A description of how the Plan uses and discloses PHI and Participants rights under HIPAA are described in the Plan's Notice of Privacy Practices. The Notice of Privacy Practices is provided upon enrollment and periodically thereafter in accordance with applicable requirements; it can be accessed any time at https://www.healthplansinc.com/members/;

(2) Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(3) Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor;

(4) Promptly report to the Plan any use or disclosure of PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

(5) Make PHI available to a Participant in accordance with HIPAA;

(6) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(7) Make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(8) Make its internal practices, books, and records, relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

(9) If feasible, return or destroy all PHI received from or on behalf of the Plan that Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed to administer the Plan. If return or destruction is not feasible, the Plan Sponsor will limit further use or disclosure to those purposes that make return or destruction of the information infeasible;

(10) Ensure there is adequate separation between the Plan and the Plan Sponsor, as required by HIPAA (45 C.F.R. §164.504(f)(2)(iii)) and described below, and that such separation is supported by reasonable and appropriate security measures:

(a) In addition to the Privacy Officer, the following Employee(s) or class(es) of Employees or other persons under the control of the Plan Sponsor ("Workforce Members") may be given access to PHI, to the extent that such access and use is restricted to plan administration functions that the Plan Sponsor performs for and on behalf of the Plan:

- Chief Financial Officer
- Director of Human Resources
- Employees and other workforce members at the direction of the above listed classes of employees
- Benefits Coordinator

(b) If the Plan Sponsor becomes aware of any Employee or Workforce Member's use or disclosure of PHI in violation of HIPAA or this Plan Document, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to address the violation, to impose appropriate sanctions, and to mitigate any harmful effects to a Participant.

(11) Implement appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;

(12) Require that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information;

(13) Report to the Plan any security incident that the Plan Sponsor becomes aware of; and

(14) Maintain adequate separation between the Plan and itself.

IX. PLAN ADMINISTRATION

A. Plan Administrator

The Plan Administrator will be appointed by the Employer.

B. Allocation of Authority

Except as to those functions reserved by the Plan to the Employer or the Board of Directors of the Employer, the Plan Administrator will control and manage the operation and administration of the Plan. The Plan Administrator shall (except as to matters reserved to the Board of Directors by the Plan or that the Board may reserve to itself) have the sole and exclusive right and discretion:

(1) To interpret the Plan, the Summary Plan Description, and any other writings affecting the establishment or operation of the Plan, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.

(2) To make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan.

All determinations of the Plan Administrator or the Board of Directors with respect to any matter relating to the administration of the Plan will be conclusive and binding on all persons.

C. Powers and Duties of Plan Administrator

The Plan Administrator will have the following powers and duties:

(1) To require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the Plan as a condition to receiving any benefits under the Plan.

(2) To make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the Plan.

(3) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan.

(4) To determine the amount of benefits that will be payable to any person in accordance with the provisions of the Plan; to inform the Employer, as appropriate, of the amount of such benefits; and to provide a full and fair review to any covered individual whose claim for benefits has been denied in whole or in part.

(5) To designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the Plan; and to retain such actuaries, accountants (including Employees who are actuaries or accountants), consultants, third-party administration service providers, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the Plan's effective administration.

D. Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons (including an insurance company or third party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the Plan. The Plan Administrator may also appoint a benefit committee consisting of not less than three (3) persons to assist the Plan Administrator either generally or specifically in reviewing claims for benefits, subject to the right of the Board of Directors to replace any or all of the members of the committee, or to eliminate the committee entirely.

The Plan Administrator, the Employer (and any person to whom any duty or power in connection with the operation of the Plan is delegated), may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including Employees who are actuaries or accountants), consultant, third-party administration service provider, legal counsel, or other specialist, and the Plan Administrator, Employer, or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.

E. Indemnification and Exculpation

The Plan Administrator and the members of any committee appointed by the Plan Administrator to assist in administering the Plan, its agents, and officers, directors, and Employees of the Employer will be indemnified and held harmless by the Employer against and from any and all loss, cost, liability, or expense that may be imposed upon or reasonably incurred by them in connection with or resulting from any claim, action, suit, or proceeding to which they may be a party or in which they may be involved by reason of any action taken or failure to act under this Plan and against and from any and all amounts paid by them in settlement (with the Employer's written approval) or paid by them in satisfaction of a judgment in any such action, suit, or proceeding. Indemnification under this Section will not be applicable to any person if the loss, cost, liability, or expense is due to the person's failure to act in good faith or misconduct.

F. Compensation of Plan Administrator

Unless otherwise agreed to by the Board of Directors, the Plan Administrator will serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Plan Administrator's duties will be paid by the Employer.

G. Bonding

Unless required by ERISA, by the Board of Directors, or by any other federal or state law, neither the Plan Administrator nor any of the Plan Administrator's delegates will be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

H. Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third-party administrative service provider, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, will be paid by the Employer unless the Employer directs the Plan to pay such expenses and such payment by the Plan is permitted by law.

X. AMENDMENT AND TERMINATION OF THE PLAN

A. Amendment of the Plan

The Employer shall have the right at any time by instrument in writing, duly executed and acknowledged, to modify, alter or amend this Plan in whole or in part, provided, however, that no such amendment shall diminish or eliminate any claim for any benefit to which a Participant shall have become entitled prior to such amendment. Notwithstanding the foregoing, the Employer shall have the limited right to amend the Plan at any time to make it compliant with existing and applicable laws and regulations, including §125 of the Code and if and to the extent necessary to accomplish such purpose, may by such amendment decrease or otherwise affect benefits to which Participants may have already become entitled.

B. Termination of the Plan

The Employer reserves the right at any time to amend or terminate the Plan.

Should the Employer decide to amend or terminate the Plan, the Plan Administrator shall be notified of such amendment or termination in writing and shall proceed at the direction of the Employer to take such steps as are necessary to modify or discontinue the operation of the Plan in an appropriate and timely manner.

XI. GENERAL PROVISIONS

A. Communication to Eligible Employees

The Employer will promptly notify all Eligible Employees of the availability and terms of the Plan.

B. In General

Any and all rights provided to any person under this Plan shall be subject to the terms and conditions of the Plan. This Plan shall not constitute a contract between the Employer and any Participant, nor shall it be consideration or an inducement for the initial or continued employment of any Employee. Likewise, maintenance of this Plan shall not be construed to give any Employee the right to be retained as an Employee by the Employer or the right to any benefits not specifically provided by the Plan.

C. No Guarantee of Non-Taxability

The Plan is designed and is intended to be operated as a component plan of a "Cafeteria Plan" under §125 of the Code. Nonetheless, neither the Employer nor any Plan fiduciary shall in any way be liable for any taxes or other liability incurred by a Participant or anyone claiming through him or her by virtue of participation in this Plan.

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's Gross Income for Federal or State Income Tax purposes, or that any other Federal or State Tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under this Plan are excludable from the Participant's Gross Income for Federal and State Income Tax purposes, and to notify the Employer if the Participant has reason to believe that any payment is not so excludable.

D. Indemnification of Employer by Participants

If any Participant receives one or more payments or reimbursements that are not for Qualifying Medical Care Expenses and/or Dependent Care Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or State Income Tax or Social Security Tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and State Income Tax that the Participant would have owed. If the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security Tax that would have been paid on such compensation, less any such additional Income and Social Security Tax actually paid by the Participant.

E. Nondiscrimination

In accordance with §125 (b) (1) and (2) of the Code, §129(e) and §105 of the Code, the Plan is intended not to discriminate in favor of Key Employees and Highly

Compensated Employees as to eligibility to participate or as to contributions and benefits, nor to provide more than *25%* of all statutory nontaxable benefits to Highly Compensated Employees. If, in the operation of the Plan, more than 25% of the total nontaxable benefits are found to be provided to Highly Compensated Employees, or the Plan discriminates in any other manner (or is in danger of so discriminating), then notwithstanding any other provision contained herein, the Plan Administrator shall reduce or adjust such contributions and/or benefits under the Plan as shall be necessary to assure that, in the judgment of the Plan Administrator, the Plan thereafter will not discriminate. All rules, procedures and decisions of the Plan Administrator shall be adopted, made and/or applied in such fashion that they do not discriminate in favor of Key or Highly Compensated Employees.

F. Coverage Pursuant to a Qualified Medical Child Support Order

Dependents shall be provided benefits in accordance with applicable requirements of any Qualified Medical Child Support Order provided that such order does not require the Plan to provide any type or form of benefit, or any option under the Plan, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in §1908 of the Social Security Act (as added by §13822 of the Omnibus Budget Reconciliation Act of 1993).

Any payment of benefits made by the Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

The terms "Qualified Medical Child Support Order" and "Medical Child Support Order" shall have the meanings given to them in §609 of the Employee Retirement Income Security Act.

An "Alternate Recipient" shall mean any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll under the Plan with respect to such Participant.

G. Company Funding

All benefits paid under this Plan shall be paid in cash from the general assets of the Employer. No Employees shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that the Employer may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Employer and an Employee or any other person. Neither an Employee nor a beneficiary of an Employee shall acquire any interest greater than that of an unsecured creditor.

H. Waiver and Estoppel

No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver

shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Employee or eligible beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

I. Nonvested Benefits

Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any Plan Participant.

J. Interests not Transferable

The interests of Participants under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, assigned or encumbered without the written consent of the Plan Administrator.

K. Severability

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Employer shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

L. Headings

All Article and Section headings in this Plan have been inserted for convenience only and shall not determine the meaning of the content thereof.

M. Applicable Law

This Plan shall be governed and construed in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Consistent with the terms of ERISA, federal law will preempt state law where applicable.

XII. MEDICAL CARE REIMBURSEMENT ACCOUNT CLAIM REVIEW PROCEDURES AND STATEMENT OF ERISA RIGHTS

The Medical Claim Reimbursement Account ("MCRA") is an employee welfare benefit Plan subject to the claims and review procedures described under ERISA.

Claims and Appeals Procedures

This section describes a Participant's rights and obligations with respect to filing claims, receiving timely notice about whether and the extent to which benefits are payable, and the option to appeal a claim that has been denied in whole or in part.

Designating an Authorized Representative

For initial claims
For the purposes of filing initial claims for coverage under the Plan, the health care provider who rendered services to the Participant is deemed to be an authorized representative, and most claims are filed by health care providers directly with the Claim Administrator. The Participant may also designate another person to be the authorized representative for filing claims by completing the applicable section of the Member Reimbursement form. The Member Reimbursement form can be completed online at the Plan web site shown on the Plan ID card; downloaded and printed; or requested from the Claim Administrator. After an authorized representative has been designated, all subsequent notices and decisions concerning claims will be provided to the Participant through his or her authorized representative. Claims are subject to the filing limits described in this Article.

Request for appeals
For the purposes of filing appeals on behalf of a Participant, the Participant's treating health care provider is deemed to be an authorized representative. The Participant may also name another individual as an authorized representative for appeals and external review by completing and submitting a Designation of Personal Representative Authorized for Claim Appeal and/or External Review Request form (DPR form), available upon request from the Claim Administrator. For a health care provider to appeal or request review of a non-Urgent Care Claim on behalf of the Participant, the Participant must execute a DPR form naming the provider as the authorized representative. After an authorized representative has been designated, all subsequent notices and decisions concerning appeals or requests for external review will be provided to the Participant through his or her authorized representative.

Exhaustion of Internal Appeals Required

Under this Plan, there are two levels of mandatory internal appeals. A Participant is required to exhaust both levels of the internal appeals process before pursuing other legal remedies that may be available. Appeals and other legal actions are subject to the filing periods described in this Article and the *General Provisions/Limitations on Actions* section of this Plan Document.

Claims and Appeals Overview

The Plan Administrator has delegated the administration of claims processing under the Plan to the Claim Administrator. As directed by the Plan Administrator, the Claim Administrator makes initial claim and initial appeal determinations based on the specific terms of the Plan. The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim, and has complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claims.

The steps involved in claims and appeals processing are outlined below. Important details about the required procedures and Participants' rights are included in Sections A-F below.

(1) All initial claims must be filed within 90 days of the end of the Plan Year in which they were incurred (please see *Claims for Reimbursement* for details). Under no circumstances are claims for services which exceed the amount of Elective Contributions to the MCRA payable under the Plan

(2) As directed by the Plan Administrator, the Claim Administrator will make an initial determination about benefits payable based on the specific terms of the Plan and will notify the Participant within the period specified for the type of claim filed (see *D. Initial Claim Determination,* and Chart A, below).

(3) If the claim is denied in whole or in part, and the Participant disputes the determination, he or she may contact the Claim Administrator to confirm that the claim was properly processed, may immediately file a formal appeal (see *F. Appeals of Denied Claims,* below).

(4) As directed by the Plan Administrator, the Claim Administrator will review the first appeal filed, and will make an appeal determination based on the specific terms of the Plan within the period specified for the type of claim that is the subject of the appeal (see *F. Appeals of Denied Claims*, Chart B below).

(5) If the first appeal is denied, the Participant may file a second appeal within the time periods specified in Chart B, below. The appeal will be reviewed by the Plan Administrator, who holds the authority to make the final determination about benefits payable under the Plan. The second appeal is the final appeal required and available under the Plan.

A. Who May File a Claim

A claim may be filed by a Participant, or by, his or her authorized representative. See *Designating an Authorized Representative,* above. After an authorized representative has been designated, all subsequent notices and decisions concerning claims will be provided to the Participant through his or her authorized representative.

B. Types of Claims

All claims under this Plan are post-service claims, i.e. they are claims for services that have already been provided.

C. When and How to File a Claim

An initial claim must be submitted by the Participant, or by the Participant's health care provider or other authorized representative by the earlier of March 31st following the close of the Plan Year in which the claim was incurred or 90 days after participation in the Plan ends. Claims received after that date will be denied. This time limit does not apply if the Participant is legally incapacitated.

Claims must be filed by:

(1) Using the debit card at the time services are rendered. (Note: After you are no longer a Plan Participant, you may no longer use the debit card; claims incurred during any applicable Grace Period must be filed as described below); or

(2) Submitting a written claim form available from the Claim Administrator, using one of the following methods:

- Electronic
- U.S. Mail
- Hand delivery
- Online submission via healthplansinc.com/members
- Facsimile (FAX): (508) 329-4815

Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581	**Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581 Attn: FSA/HRA Department

D. Initial Claim Determination/Substantiation of Eligible Expenses

After a written claim has been submitted to the Claim Administrator or after a debit card transaction has been processed, the Plan will make a determination within specified time limits. In some cases, the time limits may be extended if there are circumstances beyond the Claim Administrator's control that require a delay, or if the claim was submitted improperly or lacked information necessary to make a determination. In such cases, the Participant will be notified about the need for a delay or for additional information regarding the claim within a specified period of time.

All written claim submissions (and if requested by the Claim Administrator, all previously processed debit card transactions) must provide the following to substantiate the eligibility of the expenses being reimbursed:

- Copies of all insurance plan claim and/or payment forms (to establish amounts not paid under a medical or dental plan);
- Copies of all invoices and receipts, including debit card transaction receipts;
- The date of service;

- The name and address of the provider who rendered the service;
- The reason for the charge (i.e., the nature of the service);
- The member for whom the services were provided;
- The amount of the charges

The following table shows the applicable time limits for the Plan to respond to claim submission.

CHART A – Time Limits Regarding Initial Claims			
Maximum period after receipt of claim for initial benefits determination	**Maximum extension of initial benefits determination for delays beyond the control of Claim Administrator**	**Maximum period to notify Participant of improperly filed claim or missing information**	**Period for Participant to provide missing information**
30 days	15 days	30 days	45 days maximum

E. How Claims are Paid

If a claim is submitted, in whole or in part, and a debit card was used, payment is made directly to the provider. Otherwise payment will be made directly to the Participant. Third parties who have purchased or been assigned benefits by physicians or other providers will *not* be reimbursed directly by the Plan.

If any expense reimbursed under the Plan is later determined not to be an eligible expense under the Plan, the Employee will be required to reimburse the Plan.

F. Appeals of Denied Claims

If a claim is denied in whole or in part, a Participant may file an appeal of the adverse benefit determination. In making an appeal, the Participant has the right to designate an authorized representative to act on the Participant's behalf for the purposes of the appeal. See *Designating an Authorized Representative* at the beginning of this section.

Before filing an appeal, a Participant may first want to contact the Claim Administrator's Flexible Spending Department (877) 734-7004 to verify that the claim was correctly processed under the terms of the Plan, but is not required to do so.

Initial appeals must be filed within 180 days of the initial claim denial; second appeals must be filed within 60 days of the initial appeal denial. Any appeal received after these deadlines will be denied. Chart B below shows details of the deadlines for filing appeals and making determinations upon review.

Appeals must be in writing and must be submitted to the Claim Administrator using one of the following methods:

(1) U.S. Mail

(2) Hand delivery

(3) Facsimile (FAX): (508) 329-4815

Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581	**Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581 Attn: FSA/HRA Department

Written appeals *must* include the following information:

(1) The patient's name

(2) Sufficient information to identify the claim or claims being appealed, such as the date of service, provider name, procedure (if known) and claim number (if available)

(3) A statement that the Participant (or authorized representative on behalf of the Participant) is filing an appeal

In making an appeal, the Participant has the right to:

- Review pertinent documents and submit issues and comments in writing
- Designate an authorized representative to act on the Participant's behalf for the purposes of the appeal
- Submit written comments, documents, records, or any other matter relevant to the appeal, even if the material was not submitted with the initial claim
- Have reasonable access to, and copies of, all documents, records, and other information relevant to his or her appeal, upon request and free of charge

All appeals will be given a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the appeal, regardless of whether such information was submitted or considered in the initial benefit determination. In addition, the review will not afford deference to the initial adverse benefit determination, and the review decision will be made by individuals who were not involved in the initial claim denial and who are not subordinates of those who made the initial determination. If the denial was based on a medical judgment, the appeal will be reviewed by a health care professional retained by the Plan who did not participate in the initial denial.

If the initial appeal is denied, the Participant will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that an initial appeal is denied, the Participant will have 60 days to request a second appeal. In filing a second appeal, the Participant must follow the procedures specified under (1)-(3) above, and will have the same rights as specified for the initial appeal. The second appeal will be reviewed by the Plan Administrator

who holds final authority under the Plan to make factual findings and to interpret Plan provisions regarding the payment of benefits.

CHART B – Time Limits Regarding Initial and Second Appeals			
Maximum period for Participant to file initial appeal after initial denial	**Maximum period for issuing determination regarding initial appeal**	**Maximum period for Participant to file second appeal following denial of initial appeal in whole or in part**	**Maximum period for issuing determination regarding second appeal**
180 days	30 days	60 days	30 days

If the second appeal is denied in whole or in part, the Participant has the right to bring a civil action against the Plan under § 502(a) of the Employee Retirement Income Security Act (ERISA).

Statement of Rights

Participants in this Plan are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan Participants will be entitled to:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents governing the Plans including insurance contracts and collective bargaining agreements (if any) and a copy of the latest annual report (Form 5500 Series) filed, if applicable, by the Plan with the U.S. Department of Labor;

(2) Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies;

(3) Receive a summary of the Plan's annual financial report if the Plan is required to distribute such a summary annual financial report;

(4) Continue health care coverage for himself or herself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a COBRA Qualifying Event. The individual or his or her dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing his or her COBRA continuation coverage rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate his or her plan – called "fiduciaries" of the Plan – have a duty to do so prudently and in the interest of the individual and other Plan Participants and beneficiaries. No one, including his or her employer, his or her union (if any), or any other person, may fire the individual or otherwise discriminate against the individual in any way to prevent the individual from obtaining benefits under the Plan or exercising his or her rights under ERISA.

If his or her claim for a benefit under this Plan is denied in whole or in part the individual must receive a written explanation of the reason for the denial. The individual has the right to have the Plan review and reconsider his or her claim. Under ERISA, there are steps the individual can take to enforce the above rights. For instance, if the individual requests materials from the Plan and does not receive them within 30 days, the individual may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the individual up to $110 a day until the individual receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If the individual has a claim for benefits that is denied or ignored, in whole or in part, the individual may file suit in a state or federal court after exhausting the administrative appeals process described in this Article. In addition, if the individual disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the individual may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if the individual is discriminated against for asserting his or her rights, the individual may seek assistance from the U.S. Department of Labor, or the individual may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful the court may order the person the individual has sued to pay these costs and fees. If the individual loses, the court may order the individual to pay these costs and fees, for example, if it finds his or her claim is frivolous.

If the individual has any questions about this Plan, the individual should contact the Plan Administrator. If the individual has any questions about this statement or about his or her rights under ERISA, the individual should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his or her 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, DC 20210.