SUMMARY PLAN DESCRIPTION

FOR YOUR

SECTION 125 FLEXIBLE BENEFITS PLAN

Educators Benefit Consultants, LLC
3125 Airport Parkway, NE
Cambridge, MN 55008

Metro: 763-552-6053
Toll Free: 888-507-6053
Fax: 763-552-6055

www.tsainvest.com

Table of Contents

The Special Plan Information Sheet is included as a part of this summary.

IMPORTANT NOTES: This Summary Plan Description is intended to be only a general summary of your Plan as of the date it was prepared. As a summary it cannot cover the many situations and circumstances that might arise. Should a discrepancy ever exist between this summary and the Plan, the Plan will control. It is also not possible in the form of this summary to keep up with the changes in laws and regulations, which take place frequently. Because of this, the employer cannot assume liability for reliance upon any information contained in this summary. Please consult Educators Benefit Consultants, LLC if you have any questions.

INTRODUCTION6

What is this Plan about?

Eligible employees can now participate in our Flexible Benefits Plan ("Flex Plan" or "Plan"). A Flex Plan is an employee benefit that allows you to be reimbursed for certain expenses tax-free. You save federal, state, social security and Medicare taxes on those dollar amounts, thus increasing your take-home pay. Flex Plans are part of the U.S. Internal Revenue Code, and are designed to give employees the opportunity to pay for certain eligible living expenses with tax-free dollars.

What benefits does the Plan offer me? The following benefits are offered under the Plan:

1. **Payroll-Deducted Health Insurance.** This includes any medical, HMO, dental, vision, and other health coverage premiums paid by you through payroll deductions.
2. **Flexible Spending Arrangements** (FSAs). There are four categories:

   A. **Dependent Care:** Daycare for children under 13, care for adult dependents, preschool, and other related expenses for care of dependents. The maximum allowed is $5,000 ($2,500 if married filing separately).

   B1. **Term Life Insurance:** Employer-provided term life insurance for the employee tax-free up to $50,000 of coverage.

   B2. **Outside Health Insurance:** Premiums for personally-owned health insurance (other than those purchased through a spouse or dependent's employer).

   C. **Health:** Out-of-pocket costs for deductibles, co-payments, prescriptions, dentists, optical, transportation, medical capital expenditures, etc., not reimbursed by insurance.

A more comprehensive list of eligible expenses in each category is included in your employee information packet.

How are health insurance premiums paid?

Any health or dental insurance premium that is deducted from your paycheck will automatically be paid pre-tax after the Plan Year begins. In the unlikely event you don't want this part of the benefit, you must submit the Election to Waive Receipt of Fixed Expenses available from your Plan Administrator.

How do I participate?

To participate in the FSAs, you must complete and submit a Benefit Election Form before the beginning of the Plan Year. To do this you should make a conservative estimate of the expenses you will have in each category during the Plan Year. A worksheet is included to help you with this and you may call EBC for assistance. It is important to predict your expenses as accurately as possible because the tax regulations that govern flexible benefits plans require that you "use it or lose it." This means if you overestimate your expenses you will forfeit any excess at the end of the Plan Year. You should therefore make an election for the expenses you expect to incur. Guessing is not recommended, nor is trying to increase your tax savings by electing more than you are fairly certain you will spend.

When can I change election amounts?

Changes to the election during the Plan Year are allowed only when there is a "Change Event" in your coverage or family situation. Change Events are described on page 7.

What happens to my pay?

Over the course of the Plan Year, there will be pre-tax salary reductions equal to your total election. Tax-free reimbursements will be made for any expenses you submit. *We call the tax-free reimbursement of expenses combined with equal salary reductions "**reclassification**," since it changes your income from taxable to tax-free.* The schedule for pre-tax salary reductions and tax-free reimbursements is set out in the Special Plan Information Sheet.

What is the timing of FSA pay Reclassification under the Plan?

(a) **Non-Health FSA Expenses:** For Term Life and Outside Health Insurance coverages and Dependent Care, your pre-tax salary reduction generally occurs in the same amount, and at the same time, as you receive reimbursement of the expense tax-free. However, pre-tax salary reductions for the entire amount of your election must occur by the end of the Plan Year. If you do not submit Benefit Request Forms totaling your election amount in each category by the Plan Year end, pre-tax salary reductions will occur without a simultaneous matching reimbursement. In this circumstance you would be entitled to reimbursement upon proper submission of your Benefit Request Form.

(b) **Health FSA Expenses**: Beginning at the time set out in the Special Plan Information Sheet, there will be a pre-tax salary reduction equal to your total election divided by the number of salary reduction periods in the Plan Year. Unlike other

FSA expenses, Health FSA expenses may be reimbursed up to the total election amount regardless of the year-to-date salary reduction amount.

How do I submit expenses for reimbursement?

On a regular basis as described in the Special Plan Information Sheet, you may turn in a Benefit Request Form with copies of statements of your expenses (or receipts) from your provider(s), after which reimbursement will be made.

Please give an example how the Plan works.

Dave Brown earns $35,000 per year. During the Plan Year he will spend $1,200 for payroll-deducted health insurance, $500 for medical and dental expenses, and $2,300 in day care. The following chart shows how Dave will increase his take-home pay by using the Plan to reclassify his pay from taxable to tax-free.

Without a Plan	Dave Brown's:	With a Plan
$35,000	Annual Income	$35,000
- -	Pre-tax Eligible Expenses	-4,000
$35,000	Taxable Income	$31,000
-11,778	Taxes @ 33.65% (Assumed: Federal 20%, State 6%, FICA 7.65%)	-10,432
-4,000	After-Tax Eligible Expenses	- -
$19,222	Dave's Take-Home Pay	$20,568
DAVE'S INCREASED NET PAY		$1,346

When considering what the Plan might do for you and your family, remember the tax savings are based on your particular taxable income level. Most employees can expect to see combined Federal, FICA and state tax savings of 25% or more on the amounts they elect to have reclassified through the Plan.

ENROLLMENT AND PARTICIPATION

How does the Plan work?

The Flexible Benefits Plan increases your take-home pay because it allows you to reclassify part of your pay as non-taxable. The part you can make non-taxable is the part you intend to spend on eligible expenses.

Here's what happens. Before the Plan Year begins (or after you start employment) you make elections in the categories which apply to you. During the Plan Year you incur the expenses. Remember that the expenses or services must occur during the Plan Year. It does not matter when you pay for them. You cannot be covered during a Plan Year for expenses or services that occurred before the Plan Year began, or after it ended.

Salary reclassification will occur on a schedule established by your employer. Over the course of the Plan Year, your election amount is deducted pre-tax from your salary. Because the deduction is made before taxes are computed, you don't have to pay taxes on it. Expenses submitted for reimbursement are added to your net pay without tax. You're thus reimbursed for the expenses you submitted, and not taxed on the reimbursement.

What do I agree to when I participate?

You agree to: (a) observe all Plan rules and regulations; (b) consent to inquiries by the plan administrators of any insurance company, federal, state, or local governmental agency, or provider of dependent care, medical services, or insurance; (c) file accurately all forms and furnish any data which may be required by the Plan Administrator; and (d) be liable for any tax, penalty, and interest that might be imposed with respect to your benefits by any federal, state or local revenue agency as a result of (1) misstatements or mistakes by you or (2) inadvertent over-reimbursements made by the Employer.

What other materials will I receive?

In addition to the Summary Plan Description, you will receive:

(a) A Benefit Election Form together with documents designed to help you make a thoughtful and accurate election, and an Election to Waive Receipt of Fixed Benefits; and
(b) Benefit Request Forms together with accompanying instructions.
(c) One-on-one enrollment advice provided by a licensed financial advisor.

What are the dates of coverage for my FSA Expenses?

You may be reimbursed for your qualified expenses incurred during the Plan Year and after the date your Benefit Election Form is submitted to the Plan Administrator.

To whom do I submit my Benefit Election Form, Election Change Forms and Reimbursement Request Forms?

To the Plan Administrator or a designated representative.

What is the schedule of pay reclassification under the Plan?

The pay reclassification schedule is set out in the Special Plan Information Sheet.

What if I don't elect *before* the start of the Plan Year?

You will be deemed to have elected $0 for FSA expenses for the year. There are three ways you can later elect. The first is if you have a Change Event, as described below. The second is, if you didn't become employed by the Employer until during the Plan Year in which case, if you weren't previously in the Plan during the year, you may submit your election within a reasonable time after you've begun to perform service. The third is if you're entitled to a special enrollment right under the Health Insurance Portability and Accountability Act ("HIPAA", described below.)

What if my covered expenses during the Plan Year are less than the amounts which I elected?

You lose the difference. This is called a "forfeiture." (Thus, you should make your election carefully and safely.) Your entire election amount in all FSA categories will be deducted by the end of the Plan Year. You may submit qualified expenses for reimbursement up to six months after the Plan Year end unless otherwise determined by the Administrative Committee.

What if my covered expenses during the Plan Year are greater than the amounts I elected to be reclassified?

You may only be reimbursed for expenses up to the amount of your election. (You also will likely pay more tax for that year than you could have.)

What are the tax consequences of my reimbursements?

Reimbursements of eligible expenses generally are not included in your taxable income. Expenses that are reimbursed under the Plan may not be claimed as deductions on your federal income tax return.

GENERAL INFORMATION

From where are the benefits provided?

The Plan's benefits are either taken from the Employer's general assets, or are provided through insurance policy contracts, all of which taken together may be part of this Plan. No fund or trust has been formed for the Plan.

What if I elect the right total amount of expenses but don't have them in the right categories?

You may have a forfeiture. It's important to elect expenses in the appropriate FSA categories because you may not shuffle expenses between FSAs. The risk of a forfeiture applies to each category in which you elected too high.

What changes in the Plan may the Employer make?

The Employer may at any time amend or terminate the Plan. Any amendment or termination shall be effective on the date specified and may be retroactive with or without notice to the Participants. The Plan Administrator will let you know of any significant changes made to the Plan.

Whose responsibility is it to determine ownership of, and select beneficiaries for, insurance?

Yours. These are personal estate and financial-planning issues.

To whom should legal documents and requests for information be directed?

Service of legal process may be made and inquiries for more information may be sent to the Plan Administrator at the address listed in the Special Plan Information Sheet. The Plan (including all

related documents) may be obtained from the Plan Administrator for inspection and copying by any eligible individual, any employee, and any employee organization that represents employees of the Employer.

What records should I keep?

You should keep your original invoices, canceled checks, bank account statements, forms you filed with the Employer, your worksheets, and this Summary Plan Description for at least 7 years after the end of the Plan Year.

CHANGE EVENTS & ELECTION MODIFICATIONS

When may I change my election during a Plan Year?

You can change your election only if you have a "Change Event." A Change Event is an event that, under the law and the terms of the Plan, permits election changes. (See below.)

Upon the happening of a Change Event, you can change your election, *but only in a way that is consistent with the Change Event.* This is sometimes referred to as the "Consistency Rule."

How do I change my elections?

For all Plan benefits except payroll-deduction insurance, you can change your election by filing the Election Change Form with the Plan Administrator. For payroll-deduction insurance, you can change your election by filing the Payroll Insurance Change Notice with the Plan Administrator at the time you change your insurance coverage.

Can you give examples of the Consistency Rule? Here are some:

1. A dependent dies or loses or gains eligibility for coverage under your spouse's health insurance. While you may change your election to adjust for that dependent's situation, you may not modify your election to add or remove coverage under the Plan for another dependent.
2. You marry during the Plan Year. You may change your election to: (a) add coverage for your spouse; (b) elect Health FSA coverage for your spouse; or (c) drop coverage for yourself under the Plan in order to be covered under your spouse's insurance.

3. Your child reaches age 19 and loses eligibility for your health insurance under the Plan. You may change your Plan election to switch from family to individual health coverage or drop health insurance coverage for your child.

What are "Change Events"? They include the following:

(a) **Cost Change.** A significant cost increase or decrease in a premium for health coverage provided by an independent third-party provider, or a significant increase or decrease in cost imposed by a dependent care provider if the dependent care provider is not your relative,[1] or

(b) **Coverage Change.** A significant curtailment or cessation of coverage under a health plan provided by an independent, third-party provider during a period of coverage, or a significant change in health coverage of you or your spouse attributable to your spouse's employment, or a change in a provider of dependent care assistance or the dependent being enrolled in school during the Plan Year, or

(c) **Change in Status**: One of the following Changes in Status:

1. **Change of marital status**, including marriage, death of spouse, divorce, legal separation or annulment.

2. **Change in number of tax dependents**, including birth, adoption, placement for adoption, or death.

3. **Change of employment status**, including termination or commencement of employment by you, your spouse or dependent.

4. **Change of work schedule**, including any of the following that affect the employment status of you, your spouse or dependent: a reduction or increase in hours of employment, a switch between part-time and full-time, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite.

5. **Dependent satisfies or ceases to satisfy health plan requirements for unmarried dependents**, including attainment of age, student status or any similar circumstance as provided in your health plan.

[1] For this purpose "relative" means descendent, ancestor, stepchild, sibling, step-sibling, step-parent, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law or sister-in-law. In determining who is your relative for this purpose, children who are adopted or placed for adoption by an authorized placement agency, as well as foster children who live with their foster parents, are treated the same as other children, and half-siblings count as siblings.

6. **Residence** including a change in the residence of you, your spouse or dependent, or

(d) **Special Enrollment Right.** A special enrollment right under HIPAA arising when health coverage is terminated, described below, or

(e) **Judgment, Decree or Order.** A Judgment, Decree or Order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for your dependent child or foster child, or

(f) **Medicare/Medicaid.** A gain or loss of Medicare or Medicaid eligibility.

Are retroactive changes permitted?

Retroactive changes are not permitted except for a 30-day grace period allowing an increase in health insurance and Health FSA after the birth of a child, adoption, or placement for adoption.

When am I entitled to special enrollment rights? You may be entitled to special enrollment rights if:

(i) you decide before the beginning of the Plan Year not to elect a particular benefit because you or your dependents are covered under another plan (such as your spouse's health insurance policy), and

(ii) coverage under that other plan is later terminated because either:

(a) The coverage was continuing coverage under COBRA (the law which lets employee continue benefits after employment is terminated) and the COBRA coverage is exhausted, or

(b) The coverage was not under COBRA and was terminated because of (1) loss of eligibility for coverage, or (2) the cessation of employer contributions for the coverage.

How do I exercise special enrollment rights?

Within 30 days after coverage under the other plan ends, you submit an Election Change Form electing coverage under the Plan to replace the coverage you lost under the other plan. As usual,

the changed election must be consistent with the loss of coverage under the other plan, thus meeting the Consistency Rule.

SEPARATION FROM EMPLOYMENT

What happens if I separate from service?

You complete and submit your Separation Form prior to your separation date. You thus can get the maximum benefit to which you're entitled, and therefore the most tax savings.

If you want to continue to be covered for your elections, you can have their costs taken out of your last paycheck. (Other payment methods may be possible, but would not generate any tax savings since they would not reduce your taxable pay.) You can then be reimbursed for these expenses as you submit them.

If you don't elect continuing coverage you revoke your election when you separate from service. Health FSA expenses incurred after revocation will not be eligible for reimbursement. Other FSA expenses incurred during the Plan Year can be reimbursed after revocation, but only up to the amount of your cumulative salary reductions as of your separation date.

If you separate from employment and return in the same Plan Year, you cannot make a new election for the rest of the year. However if you are rehired within 30 days of termination, your previous election will be reinstated.

What about continuing health coverage?

Under the Plan, the reason you save money is that you reduce your taxable pay in exchange for tax-free reimbursements. After you separate from service you are left with no taxable pay to change to tax-free reimbursements. This means that, if you haven't paid for coverage by the time you separate from service, you must use after-tax dollars to pay any balance owing. Since the savings from the Plan arise because you pay for benefits with pre-tax (and not after-tax) dollars, coverage paid for after you leave service will not save taxes. You would also have to pay at least $1.02 or as high as $1.50 for $1.00 of continuation coverage.

Continued coverage may be a good decision with respect to health insurance, however, if somebody in your family has a condition which can't be covered under new or replacement insurance.

DEPENDENT CARE

What is the dependent care credit?

This is a credit against your taxes based on the amount of your dependent care expenses and your taxable income. The amount of the credit can vary from individual to individual.

Is it better to take the dependent care credit or receive dependent care reimbursement?

The answer to this question will depend on your tax bracket (for federal, state, FICA and Medicare taxes), on how much you pay for dependent care and on the amount of federal, state and local tax benefit you would receive for the dependent care expenses you expect to incur. You should project your taxes both ways, with the credit and without the credit, before you make your decision. This is because the credit may be more or less than the value of the exclusion under this Plan. If you have only one qualifying child or dependent, your ceiling for the credit is $3,000, compared to $5,000 ($2,500 if you are married filing separately) under the Plan. The maximum amount upon which you may have a tax credit on your tax return ($3,000 for one and $6,000 for two or more "qualifying individuals") is reduced by the amount you get tax-free under the Dependent Care Reimbursement Plan.

Can I be reimbursed for payment to a relative for dependent care?

You cannot be reimbursed for dependent care payments to (1) your child who is under 19 at the end of taxable year in which the payments are incurred or paid, or (2) anyone who could be claimed as a dependent on your federal income tax return for the taxable year in which the payments are paid or incurred. You can be reimbursed for dependent care payment to other relatives. However, you can't modify your dependent care election based on a cost increase if the provider is a relative. (See section on election modification.)

GROUP-TERM LIFE INSURANCE

What tax advantages relate to group-term life insurance reimbursement?

The premium for the first $50,000 of group-term life insurance is paid tax-free. Any death benefits from the insurance are also income tax-free. Insurance coverage above $50,000 is taxed based on IRS tables. Even then, the amount taxed may be less than the actual premium cost. Again, any death benefits your family receives under the insurance are income tax-free.

SOCIAL SECURITY & OTHER BENEFITS

What about Social Security?

Amounts reimbursed under the Plan are exempt from Social Security tax as well as income taxes. If you believe Social Security benefits are worth exactly what it costs you in Social Security tax, or if you feel Social Security benefits are **not** worth what they cost you from your paycheck in Social Security tax, you're better off by having all possible qualified expenses reimbursed because under the Plan you save income taxes in addition to Social Security tax. Even if you consider Social Security a bargain (compared to Social Security tax cost) you're only ahead if the benefit of Social Security is greater than the sum of Social Security tax **PLUS** the federal and state income taxes you save.

Social Security benefits are also seen by some disproportionately high compared to the dollars contributed in order to **qualify** for basic coverage, but not so high compared to dollars contributed after a larger wage base has been built up. People who won't get Social Security benefits right away usually see less value in Social Security. Overall, Flex Plan reductions in the wage base are seen by many as relatively minor when compared to a lifetime of earnings. Other factors include your life expectancy, the viability of the Social Security system, the yield you get on other investments, and your age. The Social Security Administration can help you compute how much benefit you get for an additional $1.00 in your wage base. Consult the Social Security Administration and your financial advisors if you have further questions.

What other effects may there be if my taxable income is reduced?

With reduced taxable pay, you may have a lower base for unemployment compensation and workers' compensation benefits. You may or may not also have a reduced salary base for computation of contributions to any pension, profit-sharing, stock bonus, annuity or other plan provided by the Employer. Your Plan Administrator can clarify any questions you may have.

DISABILITY BENEFITS

Must I include in taxable income benefits received from disability insurance?

This depends. If you have the disability insurance premiums reimbursed under the Plan, and you become disabled, you must report the proceeds of the policy as taxable income. However, if you have never had the premiums reimbursed, the proceeds of the policy will be **tax-free**.

FILING YOUR TAX RETURNS

What happens when I file my federal and state taxes?

There is nothing extra to do at tax time unless you've elected dependent care expenses, which you must report on IRS Form 2441. You do not have to pay extra taxes because of tax savings you experienced during the Plan Year, since your W-2 will show a taxable wage reduced by the benefits elected. Thus you don't have to "pay back" tax savings you enjoyed during the Plan Year.

LIMITS ON BENEFITS

What limitations are there for elections and reimbursement of expenses?

There are several:

(a) **Benefits Ceiling**. Your benefits can't be greater than the "Benefits Ceiling," defined as the lesser of (a) your compensation, or (b) $20,000 (unless a different amount is shown on the Special Plan Information Sheet) plus the cost of all salary reduction insurance.

(b) **Dependent Care Limitations**. Dependent Care Plan benefits are subject to the following limitations:

(1) **"Earned income" limitation**. Dependent care expense may not be greater than (a) if you're not married, your earned income, or (b) if you're married, the lesser of your earned income or your spouse's earned income. If your spouse is a student or incapacitated please refer to IRS Form 2441,"Child and Dependent Care Expenses" for instructions on computing earned income. "Earned income" doesn't include income from rents, royalties, interest, dividends and capital gains.

(2) **Overall dependent care benefits ceiling**. You may not elect more than $5,000 of dependent care expenses under the Plan ($2,500 in the case of a separate return by a married individual). The ceiling is reduced by any amounts directly reimbursed to you by the Employer.

(3) **Principal shareholders or owners**. No more than 25% of the amounts paid or incurred by the Employer for dependent care expense may be provided to the class of individuals who are principal shareholders owning more than 5% of stock or owners. If this limitation is exceeded, principal shareholders and owners will be required to have their elections or reimbursement requests reduced.

(4) **55% Rule.** If you're a highly compensated employee ("HCE," defined below) and the average dependent care benefit provided to employees who aren't HCEs is less than 55% of such benefits provided to HCEs (disregarding in either case employees whose compensation is generally less than $25,000), you may be forced either to reduce your election, reduce your reimbursement requests for dependent care expense during the year, or do a combination of the above. This factor probably won't affect the amount you decide to elect for dependent care expense, even if you are a HCE, because having to reduce your dependent care expense benefits to a lower amount will leave you no worse off than if you had elected that lower amount in the first place.

(c) **Overall limitations for highly compensated and key employees.** Key employees (defined below) of the Employer may not receive more than 25% of all benefits that are provided to all employees. If this test is violated and you are a key employee, you may be forced to reduce your election, your reimbursements, or both.

(d) **Nondiscrimination.** The plan must not discriminate in favor of HCEs, officers, 5% owners, or their spouses or dependents. If this test is violated, any qualified benefits received under the Plan by an HCE for a Plan Year shall be included in the gross income of such employee for the taxable year within which such Plan Year ends. Other possible consequences of discrimination are beyond the scope of this summary.

What is a "highly compensated employee" (HCE)?

The Internal Revenue Code generally defines a HCE for any year as one who

(i) was more than a 5% owner of the Employer in that year or the preceding year, or
(ii) had compensation for the preceding year in excess of $90,000 (indexed for inflation), and, if the employer so elects, if the employee was also in the top paid 20% of the employer's employees (ranked on the basis of compensation paid during the preceding year subject to certain exclusions).

What is a "key employee?"

The Internal Revenue Code generally defines a "key employee" as an employee who, at any time during the plan year or any of the four preceding plan years, is

(i) a voting officer of the employer having an annual compensation greater than $130,000, or
(ii) more than a 5% owner of the employer, or
(iv) more than 1-percent owner of the employer having annual compensation from the employer greater than $150,000.

EMPLOYER LIABILITY LIMITS

What limits on liability apply?

If the Employer fails to obtain insurance contemplated by this Plan, the Employer's liability shall be limited to the insurance premium, if any, unpaid for the period in question. The Employer's limit in exposure for losses or obligations with respect to insurance coverage is as follows:

(a) The Employer shall not be liable for failure to pay insurance premiums to the extent premium notices are not received by the Employer.

(b) To the extent premium notices are received by the Employer, the Employer's liability for the payment of premiums shall be limited to the amount of such premiums.

(c) Upon a Participant's separation from service, the Employer shall have no obligation to take further steps to maintain any insurance policy in force beyond any required by law. The Employer shall not be liable for the payment of any premium after a Participant's separation from service.

APPEALS PROCEDURE

What is the appeals procedure if a claim I make for expenses is denied?

If you or any other claimant want to appeal the Plan Administrator's denial of a claim for Plan benefits, contact the Plan Administrator. The Plan Administrator will supply any forms that might be needed. Within a reasonable time after receiving a claim, the Plan Administrator will give a written notice of the decision to any person whose claim for benefits has been denied. For this purpose, 90 days is a reasonable time unless the Plan Administrator notifies the claimant, within 90 days, of the expected date of the decision and the special circumstances which require an extra 90 days for processing the claim.

If the Plan Administrator's notice states a claimant is not eligible for any benefits or is not eligible for full benefits, the notice will provide specific reasons for the decision, including a reference to any pertinent Plan provision. The notice will also describe any other information needed for review of a denied claim. If the claimant receiving the Plan Administrator's decision believes that he or she is entitled to greater or different benefits, the claimant shall have the opportunity to have the claim reviewed by the Administrative Committee. This is done by filing a petition for review with the Committee, within 60 days after the Plan Administrator has given the claimant notice of a denial of any benefits. The petition should state the specific reasons that the claimant believes he or she is entitled to benefits, or greater or different benefits. The Committee will give the claimant (or a representative, if any) an opportunity to make a presentation to the Committee either orally or in writing, and the claimant will have a right to review the pertinent documents.

The Committee will send the claimant its written decision within 60 days after the Committee receives the petition, unless the Committee notifies the claimant of special circumstances requiring an extension. If special circumstances (including a need for a hearing) exist, the Committee's written decision shall state the specific basis for the decision and the specific provisions of the Plan on which the decision is based.

RIGHTS UNDER COBRA AND HIPAA

What about health continuation coverage?

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") requires that most employers sponsoring group health plans offer employees and their families the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

If you are covered by a group health plan sponsored by your employer, you and your dependents have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part), or if you are a retiree because your employer has filed for reorganization under Chapter 11 of the Bankruptcy Code. You do not have to show that you are insurable to continue your health coverage.

If you are the spouse of an employee (or a retiree for reason 5, below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following five reasons:

(1) The death of your spouse;
(2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
(3) Divorce or legal separation from your spouse;
(4) Your spouse becomes entitled to (actually covered under) Medicare; or
(5) Your spouse's employer files for Chapter 11 reorganization.

A dependent child of an employee (or a retiree for reason 6, below) covered by the Plan, has the right to continuation coverage if group health coverage under the Plan is lost for any of the following six reasons:

(1) The death of a parent;
(2) The termination of a parent's employment (for other than gross misconduct) or reduction in hours of employment with the employer;
(3) Parents' divorce or legal separation;
(4) A parent becomes entitled to (actually covered under) Medicare;
(5) The dependent ceases to be a "dependent child" under the Plan; or
(6) The parent's employer files for Chapter 11 reorganization.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the qualifying event. The Employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment or reduction in hours, or Medicare entitlement.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage.

Under the law, you have at least 60 days after the later of (i) the date you would lose coverage or (ii) the date you received notice from the Employer of the right to continue your health coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage. If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to "similarly situated employees or family members." The law requires that you be afforded the opportunity to maintain continuation coverage for 18 months because of a termination of employment or reduction in hours. If you have been determined to be disabled for Social Security purposes at the time of termination of employment or reduction in hours and have notified the Employer within 60 days of the Social Security determination and before the end of the 18-month continuation period, you may extend coverage for an additional 11 months (to 29 months). (You must also notify the Plan Administrator within 30 days of any final determination that you are no longer disabled.) If during the 18-month continuation period another qualifying event takes place, coverage may be extended up to 36 months from the date of the original event. If you are entitled to continue coverage for any reason other than termination of employment or reduction in hours, the continuation coverage period is up to 36 months.

Your continuation coverage may be cut short for any of the following reasons:

(1) The Employer no longer provides group health coverage to any of its employees;
(2) The premium for your continuation coverage is not paid in a timely fashion;
(3) You become covered under another group health plan (except when the other group health plan excludes coverage for a pre-existing condition); or
(4) You become entitled to Medicare.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. You will have a grace period of at least 45 days after you elected continuation coverage to pay any retroactive premium from the date continuation coverage starts until the date you choose continuation coverage, and 30 days in which to pay any subsequent premiums. The law says that at the end of the 18-month, 29-month or three-year continuation coverage period, you must be allowed to enroll in any individual conversion health plan provided under the Plan. The law applies to the Plan as of the date of the Plan's adoption.

If you have changed marital status, or if you or your spouse have changed addresses, please notify the Plan Administrator. The cost of the continuation coverage is usually 102% (but can be as high as 150% if disability is the reason for the continued coverage) of the cost of coverage for similarly situated employees.

This Plan saves you money primarily because it allows you to **reclassify** pay from taxable to tax-free, thus saving taxes. After you separate from service, however, you normally would have no taxable pay from your Employer to reclassify. In order to pay for coverage after you separate from service, you normally must use after-tax dollars. Coverage after you leave the Employer's service will therefore normally not save taxes. You'd also have to pay $1.02 for $1.00 of continuation coverage. The result is that continued coverage (if available) under the Flexible Benefits Plan usually makes little sense. (However, it may make sense to continue your health insurance coverage outside the Flexible Benefits Plan if somebody in your family has a condition which can't be covered with new or replacement insurance.)

What effect could HIPAA have on my benefits under the Plan?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all individuals who terminate from a group health plan subject to COBRA must be provided with certification of creditable coverage when normal coverage terminates under the plan, and again when COBRA coverage terminates. A single certification may be provided relating to all qualified beneficiaries (if the period of coverage is identical) or if the information is not identical, certifications may be provided on one form. A qualified beneficiary under HIPAA includes the spouse and dependent children of a covered employee and, in certain cases, the covered employee. A child who is born to the covered employee, or is placed for adoption with the covered employee during a period of COBRA continuation coverage is also a qualified beneficiary.

HIPAA also requires that group health plans provide for mid-year enrollment for certain individuals. For example, an individual who did not enroll in the Plan at the beginning of the Plan Year may make a mid-year election under the Health FSA if the individual, or a dependent of the individual, loses health coverage.

Health FSAs are not covered by HIPAA if two conditions are met. First, the maximum benefit cannot exceed the greater of (a) two times the employee's salary reduction election, or (b) the amount of the salary reduction election plus $500. Second, the employee must have other coverage available under a group health plan of the employer not limited to excepted benefits. If both of these conditions are met, the Health FSA is exempt from HIPAA.

FMLA EFFECT ON BENEFITS

What effect does the Family Medical Leave Act (FMLA) have on my benefits under the Plan?

An employer with 50 or more employees (for at least 20 work weeks in the current or preceding calendar year) must comply with FMLA. Basically, FMLA allows eligible employees to take up to 12 weeks (more in some states) of unpaid leave during any 12-month period:

(i) for the birth or placement of a child for adoption or foster care;

(ii) to care for the employee's parent, spouse or child who has a serious health condition; or

(iii) for medical leave if the employee is unable to work because of a serious health condition.

An eligible employee is one who has:

(i) worked for the employer for a total of at least 12 months;

(ii) worked at least 1,250 hours during the prior 12 months (approximately 32 hours per week); and

(iii) worked at a location employing at least 50 employees of the employer within 75 miles of the worksite.

The FMLA defines a serious health condition as an illness, injury, impairment or physical or mental condition that involves either:

(i) Any incapacity or treatment requiring inpatient care in a hospital, hospice, or residential medical care facility;

(ii) Any incapacity that requires an individual to be absent from work or other regular daily activities and that also requires treatment by a health care provider; or

(iii) Continuing treatment by a health care provider for a chronic or long-term condition that is incurable, or is likely to result in a period of incapacity of more than 3 calendar days.

If the employer provides group medical or dental coverage and/or health care reimbursement accounts these benefits must be continued during FMLA leave. If the employee shares the cost of health care premiums, or pays them entirely, this same arrangement also continues throughout the

leave. The employer must notify the employee in writing of the terms and conditions of the premium payment in advance of the leave. Continuation of other employer-provider benefits, such as group-term life insurance, short- term or long-term disability, is not required.

Unpaid FMLA leave qualifies as a Change Event allowing an employee to modify the Flexible Benefits Plan elections impacted by the change in status. An employee planning to take FMLA leave should carefully consider the impact it may have on his/her dependent care requirements in assessing the need for a modification. Other elections affected by the Change Event may also be modified.

Consult your Employer's human resource or personnel officer for specific guidance on requesting leave under FMLA.

DISCLAIMER

Because this summary is a brief description of our Plan and applicable laws, it does not include all of the terms, provisions, or limitations of the Plan or such laws. To the extent this summary is not complete, or is inconsistent with or varies from the Plan or laws, the language of the Plan or laws shall be controlling.

The tax rules described in this summary are written in general terms as of the date this summary was prepared. Also, state or local tax laws may vary and may affect you. Your individual circumstances and tax situation may also affect your decisions. Please consult state or local departments of revenue or your tax advisor regarding effects of state and local taxes, and your special circumstances.

The Employer is unable to guarantee favorable tax results from this Plan. Furthermore, the mere existence of a plan conforming to federal tax laws does not guarantee that the plan as operated will also comply with these laws. Finally, tax laws can change at any time without specific notice to you. The contents of this Summary Plan Description are not legal or tax advice to you. If you have further questions, please contact your advisors.