ST. LAWRENCE-LEWIS COUNTIES SCHOOL DISTRICT EMPLOYEES

FLEXIBLE BENEFITS PLAN

PLAN SUMMARY

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The school districts that participate with the St. Lawrence-Lewis Counties School District Employees Medical Plan will maintain the St. Lawrence-Lewis Counties School District Employees Flexible Benefits Plan (the "Plan") for the benefit of its eligible employees. The terms of the Plan are contained in a lengthy, legally worded document. This Plan Summary is intended to acquaint you with the provisions of the Plan that apply to you by summarizing them in language that is easier to understand.

The format for the Summary is a series of questions and answers that cover such key areas as: when you become eligible; what benefits you may receive and how your benefits are paid for. The Summary is merely intended to describe the Plan in a condensed fashion, not to change it or add to it. Should the Plan and Summary be inconsistent in any way, the provisions of the Plan will overrule the Summary.

IDENTIFYING INFORMATION

1. Plan Name and Number

   St. Lawrence-Lewis Counties School District Employees Flexible Benefits Plan: Plan Number 501.

2. Plan Administrator:

   St. Lawrence-Lewis Claims Administration Office
   PO Box 300
   Richville, NY 13681

   (315)287-2028

3. Plan Year - The district specific plan years are identified on each district's Enrollment Form

THE FLEXIBLE BENEFITS PLAN

OVERVIEW

The Plan gives you the opportunity to avoid taxes on money that you spend on certain expenses, many of them commonly occurring. The expenses that you may pay under the Plan are: your share of the cost of insurance coverage you receive through the Employer; health care expenses that are not covered by insurance; expenses for the care of your children or other dependents so that you are able to work; the cost of health or disability insurance coverage other than the cost of coverage under the Employer's insurance plans; and the cost of adopting a child. So that you and other eligible employees can enjoy the tax savings the Plan is intended to provide, the Plan is operated according to certain rules contained in the federal tax laws and regulations.

If you want to take advantage of the tax savings potential that the Plan offers, you will need to figure out the types and amounts of covered expenses that you will have each year. Then, you will need to complete an election form based on your determination. When you complete an election form, you will instruct the Employer to withhold enough money from your pay to cover your anticipated expenses. The monies withheld will be set aside to pay these expenses in the manner described below.

Unless you file an election with the Plan Administrator to the contrary (on a form available from the Administrator), you will be treated as having elected to have your pay from the Employer reduced to the extent necessary to pay through the Plan your share of the cost of the employer-sponsored insurance coverage you are receiving.

The following is a list of some of the more commonly asked questions regarding your Plan.

PLAN

The formal name of the Plan is the **St. Lawrence-Lewis Counties School District Employees Flexible Benefits Plan**

PLAN YEAR

WHAT IS THE EFFECTIVE DATE OF THE PLAN?

The first went into effect on July 1, 1999.

WHAT IS THE PLAN YEAR?

The district specific plan years are identified on each district's Enrollment Form.

ELIGIBILITY AND PARTICIPATION

WHEN AM I ELIGIBLE FOR PLAN PARTICIPATION?

You qualify to elect benefits under the Plan by becoming a Plan "Participant" as soon as you start working for the Employer.

HOW DO I PARTICIPATE?

When you become a Participant in the Flexible Benefits Plan, you will receive a form that you can use to elect the benefit options under the Plan that you desire.

PLAN CONTRIBUTIONS

HOW ARE BENEFITS PAID FOR?

Your benefits under the Plan are paid for by the amounts you have elected to be taken out of your pay to pay for your benefits. Your pay will be reduced by an amount you select on your Enrollment Form. Your reduction in salary will be applied to benefits offered under the Plan and selected by you. The Employer will credit your salary reductions to you and will draw upon them to pay for the benefits you have elected under the Plan. Your salary reductions under the Plan are *not* in your pay for income tax or Social Security tax purposes. As such, the Plan allows you to use tax-free dollars to pay for benefits and expenses that would otherwise have to be paid with taxable, out-of-pocket dollars.

WHEN ARE MY SALARY REDUCTION CONTRIBUTIONS TAKEN FROM MY PAY?

Unless the Employer tells you otherwise, your salary reduction contributions to the Plan will be withheld from your pay each pay period on a pro rata basis over the course of the Plan Year.

WILL MY SOCIAL SECURITY BENEFITS BE AFFECTED BY MY CONTRIBUTIONS TO THE PLAN?

Your Social Security benefits may be slightly reduced because, when you reduce your compensation to pay

for expenses that are covered by the Plan, the amount of contributions that are made to the Federal Social Security System to provide you Social Security benefits also are reduced.

PLAN BENEFITS

WHAT BENEFITS MAY I CHOOSE UNDER THIS PLAN?

The benefits under the Plan consist of the various categories of expenses that you may elect to pay for on a non-taxable basis, using your salary withholdings. If you want to pay for your share of the cost of insurance coverage you receive from the Employer through the Plan, elect the Insurance Premium Pre-tax Payment Option described below; if you want to pay for your uninsured health care expenses through the Plan, elect the Non-Reimbursed Medical Expense Account described below; if you want to pay for qualified dependent care expenses through the Plan, elect the Dependent Care Reimbursement Account described below; if you want to pay for medical or disability insurance coverage costs other than the cost of coverage under the Employer's insurance plans through the Plan, elect the Individual Premium Reimbursement Account described below; and, if you want to pay for adoption expenses through the Plan, elect the Adoption Assistance Reimbursement Account described below.

If you elect benefits under the Non-Reimbursed Medical Expense Account, the Dependent Care Reimbursement Account, the Individual Premium Reimbursement Account or the Adoption Assistance Reimbursement Account (collectively, the "Reimbursement Accounts"), your contributions to pay for your expenses covered by that option will be credited to an account in your name. This "Account" is for record-keeping purposes only and does not involve any actual segregation of funds.

WHAT BENEFITS ARE AVAILABLE UNDER THE INSURANCE PREMIUM PAYMENT OPTION?

You may elect under the Insurance Premium Payment Option to have premiums for coverage under the medical, dental, disability and term life insurance plans of the Employer paid from your available salary reductions. The portion of the premiums for that coverage that you elect to pay through salary reduction is deducted from your gross pay, thereby reducing your taxable income.

Unless and until you file an election with the Plan Administrator to the contrary (on a form provided to you by the Plan Administrator), you will be treated as having elected to have your pay from the Employer reduced to the extent necessary to pay through the Plan your share of the cost of any insurance coverage you are receiving through the Employer.

WHAT BENEFITS ARE AVAILABLE UNDER THE NON-REIMBURSED MEDICAL EXPENSE ACCOUNT?

If you elect the Non-Reimbursed Medical Expense Account option, you will be reimbursed for medical expenses not covered or paid for by insurance plus expenses incurred from medical care for yourself, your spouse or dependents who are under age 27 regardless of whether they are claimed as a dependent for tax purposes and which are not covered or paid for under any other plan or policy. "Medical care" for this purpose means care for the diagnosis, cure, or treatment of disease. Expenses for medical care include expenses for routine and extraordinary medical and dental examinations, vision exams and eye-wear, surgery, psychiatric care, hospitalization, prescription and physician prescribed over-the-counter drugs and medicines, therapeutic, orthopedic and prosthetic aids and devices, and transportation primarily for essential medical care.

The district specific minimum and maximum contributions are identified on each district's Enrollment Form You may elect to pay any amount greater than the district minimum up to the district maximum per Plan Year in covered expenses through this Non-Reimbursed Medical Expense Account option.

Special Rule for Participants with a Health Savings Account. If you are entitled to a contribution by your Employer to a Health Savings Account for any Plan Year, the law requires that this Plan restrict the types of expenses that may be reimbursed from your Medical Expense Reimbursement Account for that Plan Year. Under

those circumstances, the allowable expenses will be limited to expenses for dental care, and vision care.

WHAT BENEFITS ARE AVAILABLE UNDER THE DEPENDENT CARE REIMBURSEMENT ACCOUNT?

If you select the Dependent Care Reimbursement Account option, you will be reimbursed for your qualified dependent care expenses. Under the Plan, you will be reimbursed only for dependent care expenses that meet all the following conditions:

1. The Expenses were incurred for services rendered after the date you became a Participant.

2. Each individual for whom you incur the expense:

   (a) is either (i) a dependent under age 13 whom you are entitled to claim as a dependent on your federal income tax return or (ii) a spouse or other dependent for tax purposes who is physically or mentally incapable of caring for himself or herself.

   (b) lived with you for most of the calendar year; and

   (c) if the individual is a disabled adult who is not your spouse (e.g. your parent or your grandparent), he or she did not have gross income for the calendar year that was more than the amount of the personal exemption deduction under federal tax law for that year.

3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.

4. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

5. The expenses are not paid or payable *to* a child of yours who is under age 19 at the end of the year in which the expenses are incurred.

6. The expenses are not paid or payable *to* an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

WHAT EFFECT WILL PARTICIPATION IN THE DEPENDENT CARE REIMBURSEMENT ACCOUNT HAVE ON MY RIGHT TO THE DEPENDENT CARE CREDIT ON MY TAX RETURN?

To the extent you use your reimbursement account to pay for dependent care expenses, you cannot use the Federal dependent care credit when you file your income tax return. The dollar amount of expenses eligible for the dependent care credit must be reduced, dollar for dollar, by the amount of expenses excluded from income through spending accounts. For some people the tax credit may be more favorable than the reimbursement account. In other situations, the reimbursement account will be more favorable. Therefore, before deciding to use a reimbursement account for dependent care, you should determine which is more favorable for you.

ARE THERE ANY LIMITS ON THE AMOUNT THAT MAY BE EXCLUDED FROM MY PAY FOR DEPENDENT CARE ASSISTANCE?

Yes. In general, the amount of expenses that you may pay through the Dependent Care Reimbursement Account option is limited to $5,000 per *calendar* year ($2,500 if you are married but you and your spouse file separate tax returns). However, the amount of expenses can never exceed your earnings for the year or the earnings of your spouse, whichever is lower. Special rules apply in determining the earnings of a spouse who is a student or incapable of caring for himself or herself.

WHAT BENEFITS ARE AVAILABLE UNDER THE INDIVIDUAL PREMIUM REIMBURSEMENT ACCOUNT?

If you elect benefits under the Individual Premium Reimbursement Account, you will be reimbursed for the costs of health or disability insurance coverage on your spouse, your dependent children or you, other than your coverage under the Employer's insurance plan. For example, you could use this benefit option if you purchase and pay for a health insurance policy for a child who is no longer eligible for coverage under your Employer's health insurance plan but is still a dependent of yours for tax purposes.

You may elect to pay an amount up to $10,000 per Plan Year in covered expenses through this Individual Premium Reimbursement Account option.

REMINDER: Pre-taxed premiums are not allowed for reimbursement under this account.

WHAT BENEFITS ARE AVAILABLE UNDER THE ADOPTION ASSISTANCE REIMBURSEMENT ACCOUNT?

The Adoption Assistance Reimbursement Account option provides reimbursement to you for the reasonable and necessary expenses that you incur in the process of legally adopting an eligible child, including adoption fees, court costs and attorney fees. Expenses that are not eligible for reimbursement include expenses incurred in violation of state or federal law, expenses incurred in carrying out a surrogate parenting arrangement, and expenses in connection with the adoption of a step-child. An "eligible child" is a child who has not yet reached age 18 or is physically or mentally incapable of caring for him or herself. The maximum amount of reimbursement that you may receive in connection with the adoption of any one child is $12,150 (this amount will be adjusted for inflation). **This is a total rather than an annual amount, even if the expenses occur over a period of years.**

WHAT ARE THE TAX BENEFITS OF REIMBURSEMENT UNDER THE ADOPTION ASSISTANCE REIMBURSEMENT ACCOUNT?

If your adjusted gross income (together with that of your spouse if you are married and filing a joint tax return) is $182,180 (this amount will be adjusted for inflation) or less, you can exclude from your gross income in computing your income tax liability the entire amount of adoption expense reimbursement you receive under this Plan (subject to the $12,150 cap). However, if your adjusted gross income exceeds $182,180, the portion of adoption expense reimbursement that may be excluded is reduced from $12,150 based on the following formula:

$12,150 x [(adjusted gross income - $182,180) / $40,000]

If, for example, your adjusted gross income were $202,220 and you incurred $12,150 or more in expenses to adopt a child, your maximum exclusion would be $6,075, calculated as follows:

$12,150 x ($20,000 / $40,000), or $12,150 x .5 = $6,075

$12,150 total expenses - $6,075 pre-tax reduction = $6,075 of expenses that may be reimbursed pre-tax

Generally, any amounts paid to reimburse you for eligible adoption expenses would be excluded from your income for the year of reimbursement. However, should you adopt a child who is not a citizen or resident of the United States, all amounts reimbursed to you would be excludable from your income only in the year in which the adoption becomes final.

While the amount of your salary that is withheld to pay adoption expenses is excluded from your income in determining your income tax liability, FICA (Social Security) and FUTA (Unemployment) taxes still apply.

WHAT AFFECT WILL PARTICIPATION IN THE ADOPTION ASSISTANCE REIMBURSEMENT ACCOUNT HAVE ON MY RIGHT TO THE ADOPTION EXPENSES CREDIT ON MY TAX RETURN?

The federal tax laws also provide a tax credit (reducing federal tax liability) for adoption expenses that are not reimbursed by an employer or paid under a state or federal grant program. The maximum amount of the credit is $12,150 per adoption (subject to inflation adjustments). You may claim both a credit and reimbursement exclusion in connection with the same adoption, provided they are not claimed with respect to the same expense. Because any election for benefits under the Adoption Assistance Reimbursement Account should be coordinated with the use of the credit, the Administrator strongly recommends that you seek advice from your own tax advisor before electing benefits under the Adoption Assistance Reimbursement Account.

REIMBURSEMENT ACCOUNT CLAIMS

HOW DO I RECEIVE REIMBURSEMENT ACCOUNT BENEFITS?

You obtain reimbursement for expenses allowed under the Reimbursement Accounts by submitting reimbursement claim forms and documentation from the provider of the services you received (e.g., a receipted bill, an unpaid bill, or a signed affidavit) stating the nature, date and amounts of the expense. A reimbursement claim form submitted under the Dependent Care Reimbursement Account must include the name, address and taxpayer identification number of the dependent care service provided. In the case of a babysitter, the taxpayer identification number is the babysitter's Social Security number. It is your responsibility to maintain adequate records to verify these expenses. **You must apply for reimbursement on or before the 90th day following the close of the Plan Year.** Upon receiving a properly completed reimbursement claim form accompanied by the appropriate documentation from you, the Administrator will distribute to you or your beneficiary the amount to which you are entitled.

WHAT IS THE MAXIMUM AMOUNT I CAN RECEIVE?

If, for any Plan Year, you make an election under the Non-Reimbursed Medical Expense Account option, the amount that you elect will be immediately credited to a Non-Reimbursed Medical Expense Account in your name. Starting on the first day of that Plan Year, you will be entitled to be reimbursed for claims up to the entire elected amount (reduced by the amount of Medical Expense claim payments you already received for that year) at any time during the Plan Year, even if the total salary reduction contributions that you have made to your Non – Reimbursed Medical Expense Account are less than the total amount of claims that you have submitted.

For claims under any of the other Reimbursement Account options, the largest amount that you will be entitled to be reimbursed for at any point will be the amount that is in your Reimbursement Account at the time a claim is filed.

WHAT HAPPENS IF MY CLAIM FOR BENEFITS IS DENIED?

When a Claim is Denied

You will be notified in writing by the Plan Administrator if a claim that you submitted has been denied. As a general rule, you will receive notification of a claim denial within 30 days of the date you submitted your claim. However, the 30-day period may be extended for an additional 15 days due to circumstances beyond the Plan Administrator's control. This would be the case if, for example, you did not include enough information about a particular claim for the Plan Administrator to either allow or deny the claim.

The Plan Administrator will provide you with written notice if it becomes necessary to extend the 30-day period with regard to any claim that you file. The written notice will tell you the reason for the extension and when

the Plan Administrator expects to make its decision. If the reason for the extension is that your claim was incomplete, you will also be notified of what additional information the Plan Administrator needs to allow or deny your claim, and you will be given 45 days after you receive the notice to provide the information during which time the claims submission deadline will be suspended.

Any notification that you receive from the Plan Administrator denying a claim that you have submitted will include:

1. The reason or reasons that your claim was denied;

2. The specific Plan provision on which the denial was based;

3. A description of any additional material or information that you would need to have your claim approved and an explanation of why that additional material or information is needed; and

4. Information on the steps that you must take to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered your right to review, upon request and at no charge, relevant documents and other information.

Appealing a Claim Denial

If the Plan Administrator denies your claim or any part of your claim, you or an authorized representative of yours may apply to the Plan to review the denial. Your appeal must be made in writing within 180 days after you received notification from the Plan Administrator that your claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to sue in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts or documents that you believe to support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review, upon request and for no charge, documents and other information relevant to your appeal.

Decision on Review

The Plan Administrator will review and decide your appeal in a reasonable time not later than 60 days after he or she receives your request for review. The Plan Administrator may, in his or her discretion, hold a hearing of the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. You will be informed of the identity of any medical expert consulted in connection with your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review that will include:

1. The specific reasons for the decision on review;

2. The specific Plan provision or provisions on which the decision is based;

3. A statement of your right to review, upon request and at no charge, relevant documents and other information; and

4. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

WHAT HAPPENS TO MONEY LEFT IN MY REIMBURSEMENT ACCOUNT?

Any amounts in your Non-Reimbursed Medical Expense Account, Dependent Care Reimbursement Account, Individual Premium Reimbursement Account or Adoption Assistance Reimbursement Account at the end of the permissible reimbursement period for a Plan Year will be forfeited and used by the Employer to offset

administrative expenses and future costs. Because your salary reduction contributions not used to reimburse you for expenses incurred in the Plan Year will be forfeited, it is important that you carefully determine the proper amount of your pay to allocate to each account.

MID-YEAR CHANGES

WHAT HAPPENS IF I TAKE A LEAVE OF ABSENCE?

If you take a leave of absence from your employment with the Employer, your election of benefits under the Plan will remain in effect if you will continue to be paid by the Employer during that leave. If, on the other hand, your leave is unpaid, you will have the opportunity, before the leave starts, to revoke your election and, if desired, make a new election in accordance with the rules discussed below at the Section entitled, "May I Change My Benefit Election?"

If you take a leave of absence to which the Family Medical leave Act of 1993 ("FMLA") applies, during the period of such leave you will have the option of continuing your coverage under the Employer's medical insurance plan and Non-Reimbursed Medical Expense Account on the same terms and conditions as though you were still an active Employee (i.e., the Employer will continue to pay its share of the premium to the extent you elect to continue your coverage). You may do so by either paying your share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent you receive compensation during the leave), or by prepaying all or a portion of your share of the premium for the anticipated duration of the leave on a pre-tax salary reduction out of your pre-leave compensation by making a special election to that effect prior to the date such compensation normally would be made available to you (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next year), or through other arrangements agreeable to the Administrator. Upon return from FMLA leave, you will be permitted to reenter the Plan on the same basis on which you were participating prior to taking leave.

MAY I CHANGE MY BENEFIT ELECTION?

While you may change your election before the beginning of a new Plan Year, as a rule, you may not change an election of benefits during the Plan Year. However, if you experience any of the following events, you may revoke your election after the Plan Year has commenced and make a new election for the balance of the Plan Year:

1. *Change in Status.*

   (a) A change in your legal status (e.g., marriage, death of your spouse, divorce, legal separation or annulment).

   (b) A change in the number of your dependents due to events such as birth, adoption, placement for adoption or death.

   (c) A termination or commencement of employment by your spouse or dependent.

   (d) A reduction or increase in the hours that you, your spouse or your dependent works, including a switch between part-time and full-time status and commencement or return from an unpaid leave of absence. In addition, if the eligibility conditions of this Plan or of any other employee benefit plan that you, your dependent or your spouse depend on the employment status of the individual and a change in that individual's employment status causes that individual either to become eligible or cease to be eligible under the plan, that change constitutes a Change in Status.

   (e) An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements for a certain benefit (e.g., due to attainment of a certain age).

If you wish to change your election based on a Change in Status, the change must be consistent with that Change in Status, under the following rules:

> Your change of election will be considered to be consistent with a Change in Status only if the Change in Status results in you, your spouse or your dependent gaining or losing eligibility for a benefit (or particular benefit option) under a plan of the Employer or under a plan of your spouse's or dependent's employer, and the change of election corresponds with that gain or loss of coverage, or, if the Change in Status affects dependent care expenses described in Code Section 129 or Code Section 137.

If the Change of Status is your divorce, annulment or legal separation, the death of your spouse or dependent, or your dependent ceasing to satisfy the eligibility requirements for coverage, your election under the plan to cancel accident or health coverage for any individual other than your spouse involved in the divorce, annulment or legal separation, your deceased spouse or dependent or the dependent that ceased to satisfy the eligibility requirements for coverage, as the case may be, fails to correspond with that Change in Status. In addition, if you or your spouse or dependent gains eligibility for coverage under this Plan, another cafeteria plan or any other plan providing benefits that are nontaxable benefits under Code Section 125 as a result of a change in marital status or a change in employment status described above, an election under this Plan to cease or decrease coverage for that individual corresponds with that Change in Status only if coverage for that individual becomes available or is increased under the plan from which eligibility for coverage has been gained. However, a change of election regarding disability income or term-life insurance coverage may correspond with a Change in Status whether the change involves an increase or a decrease in coverage.

If you or your spouse or dependent become eligible for COBRA continuation coverage, you may elect to increase payments under this Plan to pay for that coverage.

1. *Special Enrollment Rights.* You, your spouse and/or your dependent may change your election for the balance of the Plan Year and file a new election that corresponds with any special enrollment rights you may have under a group health plan.

2. *Certain Judgments and Orders.* If a judgment, decree or order from a divorce, legal separation, annulment or custody change requires that your child, or a foster child who is your dependent, be covered under the Employer's health plan or the health plan of your former spouse's employer, you may change your election to provide coverage for the child under the Employer's plan if the order requires it or change your election to cancel coverage for the child under the Employer's plan if the order requires your spouse or former spouse, or any other individual, to provide the coverage.

3. *Entitlement to Medicare or Medicaid.* If you, your spouse or your dependent becomes entitled to coverage under Medicare or Medicaid, you may cancel that person's accident or health coverage. In addition, if you or your spouse or dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for that coverage, you may make a prospective change of election to commence or to increase that person's coverage under the accident or health plan.

4. *Change in Cost or Coverage.* A change of cost or change of coverage with respect to non-cash benefits that may be elected under this Plan may be the basis for a change of election based on the following rules:

   (a) These rules do not apply to benefits under the Non-Reimbursed Medical Expense Reimbursement Account.

   (b) If the cost of any of your benefits increases or decreases during a period of coverage and, as a result, you are required to increase or decrease your payments for those benefits, your salary reduction's contributions under this Plan will be adjusted accordingly, unless you make a change to your election under (c) below.

(c) If the cost of any of your benefits significantly increases during a period of coverage, you may elect either to increase your contributions to pay for the increased cost or to revoke your election and to receive instead coverage under another benefit option of the plan providing the benefits. If the cost of any benefit or benefit option significantly deceases during a period of coverage for which you have not elected that benefit or benefit option, you may make a new election of that type of benefit or benefit option. If you have an election in effect at that time for that type of benefit (e.g., medical insurance coverage) but under a benefit option other than the one the cost of which has significantly decreased, you may revoke that existing election and elect the benefit option that has significantly decreased in cost.

(d) You may only change your election due to an increase in the cost of dependent care assistance benefits if your dependent care provider is not your relative.

(e) If your coverage under any benefit plan is significantly reduced or stops, you may make a new election going forward of any other coverage option available under that plan. Coverage under an accident or health plan is considered to be reduced only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage to Participants generally.

(f) You may make an election change that is on account of and corresponds with a change made under a benefit plan of your spouse, former spouse or dependent if that plan allows for election changes based on a change in cost or coverage consistent with the foregoing rules and if that plan permits participants to make an election for a period of coverage under the cafeteria or other plan that is different from that under this Plan.

(g) For purposes of adoption assistance provided through the Plan, the commencement or termination of an adoption proceeding.

(h) You may make an election change that is on account of and corresponds with a change made under a benefit plan of your spouse, former spouse or dependent if that plan allows for election changes based on a change in cost or coverage consistent with the foregoing rules and if that plan permits participants to make an election for a period of coverage under the cafeteria or other plan that is different from that under this Plan.

5. *Changes in Coverage Attributable to Spouse's Employment.* You may revoke a prior election and make a new election where there has been a significant change in benefit plan coverage for you, your spouse or of dependent of yours related to your spouse's or dependent's employment, if that change of election is determined by the Administrator to be consistent with the change in benefit plan coverage.

Even if you are permitted to change your election under these rules, you may not change your election for Non-Reimbursed Medical Expense Account, Dependent Care Reimbursement Account, Individual Premium Reimbursement Account or Adoption Assistance Reimbursement Account benefits below the amount of such benefits already reimbursed for the Plan Year.

IMPORTANT NOTE: Remember, unless you experience one of the limited circumstances allowing for election changes during the Plan Year, you will not be able to reduce or increase the amounts designated on your enrollment form, nor will you be able to change amounts from one account to another. This is why you are encouraged to plan carefully before you enroll in this Plan.

The Administrator must be notified within 30 days of any such event to make a change.

If you fail to submit a new election form for any new Plan Year, your election of the Insurance Premium Payment Option will remain the same as for the prior year, but you will be considered not to have elected any benefits under the Non-Reimbursed Medical Expense Account, Dependent Care Reimbursement Account, Individual Premium Reimbursement Account or Adoption Assistance Reimbursement Account Options for the new

year.

MAY MY ELECTION BE CHANGED WITHOUT MY CONSENT?

If the Plan Administrator determined before or during any Plan Year that the Plan may fail to satisfy any nondiscrimination requirements imposed by the Internal Revenue Code, the Administrator may take action to assure compliance with any requirements or limitations. This action may include a modification of any elections with or without the consent of the Employee.

WHAT HAPPENS IF I STOP WORKING FOR THE EMPLOYER OR I BECOME INELIGIBLE FOR THE PLAN FOR ANOTHER REASON?

Subject to any rights you may have to continuation coverage as discussed below, you will lose eligibility for the Plan if you stop working for the Employer. This means that your contributions to the Plan will cease. However, you will be permitted to submit Non-Reimbursement Medical Expense Account claims for expenses you have incurred at any time prior to the date your participation terminates, until 90 days after the end of the Plan Year. The amount available for reimbursement will be the benefit amount you elected for the year (as adjusted for any mid-year election changes you were permitted to make), reduced by the amount of prior medical expense reimbursements for the year. You will be permitted to submit claims under any other Reimbursement Account option for expenses you have incurred at any time during the Plan Year in which your participation ceases at any time until 90 days after the end of the Plan Year. The amount available for reimbursement will be whatever is left in your Account at the time your eligibility ceases.

CONTINUATION COVERAGE

ARE THERE ANY CIRCUMSTANCES UNDER WHICH I MAY CONTINUE TO RECEIVE COVERAGE AFTER MY EMPLOYMENT TERMINATES?

COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under a group health plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are covered under the plan when you would otherwise lose your group health coverage.

The COBRA Law generally applies to all "group health plans' maintained by an employer. However, the purpose of this section of the Summary is limited to **explaining the COBRA rules that could allow you to continue your coverage in the Non-Reimbursed Medical Expense Account portion of the Flexible Benefits Plan if you became ineligible under the Flexible Benefit Plan's normal eligibility provisions at a time when you had a Non-Reimbursed Medical Expense Account.**

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Only qualified beneficiaries may elect to continue their group health plan coverage. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for

COBRA continuation coverage.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plans who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights. Specific information describing the coverage to be continued under the Plan is contained elsewhere in this document.

As an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

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

The spouse of an employee will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events happens:

(a) His or her spouse dies;
(b) His or her spouse's hours of employment are reduced;
(c) His or her spouse's employment ends for any reason other than his or her gross misconduct;
(d) His or her spouse becomes enrolled in Medicare (Part A, Part B or both); or
(e) He or she becomes divorced or legally separated from the employee. If an employee cancels coverage for his or her spouse in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days after the divorce or legal separation and can establish that the employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.

An employee's dependent child will become a qualified beneficiary if he or she will lose coverage under the plan because any of the following qualifying events happens:

(a) The parent-employee dies;
(b) The parent-employee's hours of employment are reduced;
(c) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(d) The parent-employee becomes enrolled in Medicare (Part A, Part B or both);
(e) The parents become divorced or legally separated; or
(f) The child stops being eligible for coverage under the plan as a "dependent child."

Special Eligibility Rules Apply

Under special rules that apply to "health flexible spending account" plans like the Non-Reimbursed Medical Expense Account, the Plan may only be required to offer COBRA continuation coverage to you or your family members if you have a positive Account balance in your Non-Reimbursed Medical Expense Account at the time the qualifying event occurs. You will have a positive Non-Reimbursed Medical Expense Account balance at the time a Qualifying Event occurs if your total contributions to the Account for the Plan Year to date are more than your total Plan Year to date reimbursements from the Account (including for this purpose, any claims that have been submitted but not paid).

Notifying the Plan Administrator of Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the employee in Medicare (Part A, Part B or both), the Employer must notify the Plan Administrator of the Qualifying event within 30 days

after the event occurs.

Important: For the other qualifying events (divorce or legal separation of the employee or spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

Notice Procedures

Any notice that you provide must be in writing. You must mail your notice to the Plan Administrator unless you are otherwise instructed by the Plan Administrator. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state the name of the Plan, the name and address of the employee covered under the plan, and the name and address of any qualified beneficiary. Your notice must also name the qualifying event and the date it happened.

The Plan's form of Notice of Qualifying Event should be used to notify the Plan Administrator of a qualifying event. A copy of this form can be obtained from the Plan Administrator. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Your notice of a second qualifying event also must name the event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Your notice of disability must also include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination. Your notice of disability must include a copy of the Social Security Administration's determination.

The Plan's form of Notice by Qualified Beneficiary should be used to notify the Plan Administrator of a second qualifying event, a disability determination or a determination that a qualified beneficiary is no longer disabled. A copy of this can be obtained from the Plan Administrator.

Electing COBRA Continuation Coverage

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of the dependent children only. A qualified beneficiary must elect coverage in writing within 60 days of being provided a COBRA election notice, using the plan's election form and following the procedures specified on the election form. (A copy of the plan's election form may be obtained from the Plan Administrator). Your written notice must be provided to the Plan Administrator at the address provided on the plan's election form. If you mail your election, it must be postmarked no later than the last day of the 60-day election period. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE. A qualified beneficiary may change a prior rejection of continuation coverage any time until the end of the 60-day election period, in writing, by using the election form and following the procedures specified on the election form.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You will lose the guaranteed right to purchase individual health insurance policies if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible

(such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of employment or reduction of the employee's hours of employment, death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. COBRA continuation coverage for employees and qualified beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Special Rules May Shorten Your COBRA Continuation Coverage

Under special rules that apply to "health flexible spending account" plans like the Non-Reimbursed Medical Expense Account, the Plan may only be required to offer COBRA continuation coverage to you or your family members until the end of the Plan Year in which you lose coverage under the Flexible Benefit Plan's normal eligibility provisions.

Termination of COBRA Continuation Coverage before the End of the Maximum Coverage Period

Continuation coverage will be terminated before the end of the maximum period if (1) any required premium is not paid on time; (2) after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary; (3) after electing COBRA coverage, a qualified beneficiary enrolls in Medicare; or (4) the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

You must notify the Plan Administrator in writing within 30 days, if, after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan or enrolls in Medicare Part A or B. You must use the notice procedures described above under "Notice Procedures." The Plan reserves the right to retroactively cancel COBRA coverage and in that case will require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

Cost of Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Payment for Continuation Coverage-First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation with the election form. However, you must make your first payment for continuation coverage within 45 days after the date of your election (This is the date the Qualifying Event Election Notice is post-marked, if mailed). If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the plan would have otherwise terminated through the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

Payment for Continuation Coverage - Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the plan, these periodic payments for continuation coverage are due on the first day of each month of coverage. If you make a periodic payment on or before its due date, your coverage under the plan will continue for that coverage period without any break. The plan will send periodic notices of payments due for these coverage periods. A notice is only a reminder to you to pay. It is not a bill. You must make your payment by the due date or within the grace period (discussed below) whether or not you receive a notice.

Periodic payments for continuation coverage should be sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Opinion to Elect Other Health Coverage besides COBRA Continuation Coverage

Under the plan, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

More Information about Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with covered employee during COBRA period

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation

coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order ("QMSCO") received by the Plan Administrator during the covered employee's period of employment with the employer is entitled to the same rights under COBRA as a dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator, or you may contact the nearest Regional or Employer Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and Employer ESBA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Administrator Informed of Address Changes

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

USERRA

A federal law known as "USERRA" may require that Participants who cease to be eligible to receive health care coverage because of duty in the uniformed services be given the right to buy continued health coverage on an after-tax basis for up to twenty-four months. USERRA also requires that for Participants who are expected to perform service in the uniformed services for less than 31 days, the Employer may not require the Participant to pay more than his or her share, if any, of the premium. To the extent required by applicable federal laws, the Administrator will implement and administer the procedures designed to comply with federal laws requiring the provision of continued coverage and plan participation and will give you notice of your rights under these laws.

MISCELLANEOUS

CAN MY EMPLOYER TERMINATE OR CHANGE THE PLAN?

The Employer has the right at any time to amend in whole or in part any or all of the provisions of the Plan. However, no amendment may be passed which authorizes or permits any part of your account to be used or diverted for a purpose other than providing benefits to you and your beneficiaries.

The Employer also has the right at any time to *terminate* the Plan.

WHO PAYS THE COSTS OF THE PLAN?

The Employer pays the cost of administering the Plan.

THIS SUMMARY IS NOT MEANT TO INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. IN CASE OF A CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN, THE PROVISIONS OF THE PLAN WILL ALWAYS GOVERN YOUR RIGHTS AND BENEFITS.