SECUR-SERV
OMAHA NE

Flexible Spending Summary Plan Description
7670-02-416613, 7670-03-416613

Revised 01-01-2026

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

Table of Contents

SECUR-SERV

FLEXIBLE SPENDING PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You with summary information on benefits available under this Plan, as well as with information on Your rights and obligations under Your employer's sponsored Flexible Spending Plan (also known as a Cafeteria Plan). You are a valued Employee of SECUR-SERV, and Your employer is pleased to provide You with benefits that can help meet Your health care and Dependent care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions. This document summarizes the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document. Therefore, it will be referred to as both the SPD and Plan document. It is being furnished to You in accordance with ERISA.

The Plan is intended to qualify as a Cafeteria Plan under Code §125. The purpose of the Cafeteria Plan is to allow Employees to choose between two or more benefits consisting of cash and certain qualified benefits, namely coverage under a variety of benefit plans sponsored by Your employer.

The Cafeteria Plan offers You flexible spending account choices as well as other benefit options. Benefit options offered under the Cafeteria Plan are separate plans for purposes of administration and legal compliance. The following options are components of the Cafeteria Plan:

- Health Care Flexible Spending Account (Health FSA)
- Dependent Care Spending Account
- Limited Purpose Health Care Flexible Spending Account (Health FSA)
- Medical Benefits Plan
- Health Savings Account (HSA)
- Dental Plan
- Vision Plan

SECUR-SERV is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of an independent Third Party Administrator, UMR, Inc. (hereinafter "UMR") to process claims and perform other administrative duties for the Plan. As the Third Party Administrator, UMR does not assume liability for benefits payable under this Plan, since it is solely a claims-paying agent for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of its general assets; however, Employees cover most of the costs of the Flexible Spending Account with pre-tax contributions from their pay. All claim Payments and reimbursements are paid out of the general assets of the employer and there is no trust or other separate fund from which benefits are paid. Even though this Plan may allow pre-tax-salary reduction contributions to an HSA, the HSA funding feature is not part of or intended to be part of an ERISA benefit plan sponsored or maintained by the Employer.

The requirements for coverage under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), and the procedures that must be followed in making claims for benefits and appeals of denied claims are outlined in the following pages of this SPD.

Some of the terms used in this document begin with capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

This document became effective on January 1, 2024.

PLAN INFORMATION

Plan Name	SECUR-SERV FLEXIBLE SPENDING PLAN
Name And Address Of Employer	SECUR-SERV 2020 S 156TH CIR OMAHA NE 68130
Name, Address, And Phone Number Of Plan Administrator	SECUR-SERV 2020 S 156TH CIR OMAHA NE 68130 651-683-6009
Named Fiduciary	SECUR-SERV
Employer Identification Number Assigned By The IRS	95-2767912
Plan Number Assigned For The Health Care Spending Account	505
Type Of Benefit Plan Provided	Self-Funded Medical Reimbursement Plan under Code §105(b) and Dependent Care Assistance Plan under Code §129.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator with benefits provided in accordance with the provisions of the employer's Flexible Spending Plan. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim Payments and enrollment services.
Name And Address Of Agent For Service Of Legal Process	SECUR-SERV 2020 S 156TH CIR OMAHA NE 68130
Funding Of The Plan	Employee Contributions Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer.
ERISA Plan Year	Begins on January 1 and ends on the following December 31.

Compliance

It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and, in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

CAFETERIA PLAN HIGHLIGHTS

SECUR-SERV's Cafeteria Plan allows Employees to use pre-tax dollars to pay for their portions of the necessary contributions on a Salary Reduction basis for the component benefits offered.

The following benefits and accounts are offered under this Cafeteria Plan:

- Health Care Flexible Spending Account (Health FSA)
- Dependent Care Spending Account
- Limited Purpose Health Care Flexible Spending Account (Health FSA)
- Medical Benefits Plan
- Health Savings Account (HSA)
- Dental Plan
- Vision Plan

PARTICIPATION IN A COMPONENT BENEFIT PLAN / ACCOUNT

In order to participate in a specific component benefit offered under this Cafeteria Plan, You must elect that component benefit on forms provided by the Plan Administrator, and You will be required to share the cost of the component benefit as explained below. Further, You must meet any eligibility, participation, or other requirements applicable to that component benefit plan or account.

EMPLOYEE CONTRIBUTIONS

Other than for the Health FSA, Dependent Care Spending Account, and HSA, Your contribution amount for the component benefits offered under this Cafeteria Plan will be established by the Plan Administrator in its sole discretion.

PAYING THE CONTRIBUTIONS FOR THE APPLICABLE BENEFIT PLAN / ACCOUNT

As an Employee, You will pay the applicable contribution amount on a pre-tax Salary Reduction basis. Your election will be irrevocable for the entire Plan Year, unless You experience a Change In Status event (see below) that would permit an election change, or unless some other regulatory exception applies. With regard to the Health Savings Account Benefit, a Participant who is actively enrolled in a qualified high deductible Health Plan and not enrolled, including as a Dependent, under a non-qualified high deductible Health Plan or any other disqualifying coverage, and has elected to make elective contributions under such arrangement, may modify or revoke the election at any time, prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder. Please see Your Human Resources Representative if You have any questions.

USE-OR-LOSE RULE (Does not apply to the HSA)

Plan Your health care and/or dependent care elections carefully. Any unused benefits or contributions in Your health or dependent care account will be forfeited if they are not used to pay or reimburse expenses that You or Your Dependents (if applicable) incur by the end of the Plan Year or by the end of the grace period with the exception of a permitted health care FSA carryover amount as stated elsewhere within this document. Forfeited amounts will be used to offset reasonable administrative expenses and future costs of the applicable benefit plan. Refer to the Plan's timely filing provision for details regarding the deadline for submitting claims.

GRACE PERIOD (Applies to the Health Care and Dependent Care Spending Account(s) only)

If You are enrolled in the Health FSA and the Dependent Care Spending Account as of the end of the Plan Year, You are eligible for a two and a half month grace period. The grace period allows You and Your Dependents (if applicable) to continue incurring Medical Care Expenses and Dependent Care Expenses for up to two and a half months following the end of the Plan Year and to be reimbursed for those expenses with any remaining account balance from the prior Plan Year.

If You were enrolled in the limited-purpose Health FSA option, You will be limited during the Plan's grace period to dental and vision expenses that are eligible under this Plan, as well as to other benefits permitted by IRS published guidance.

The Medical Care Expenses and Dependent Care Expenses that You and Your Dependents (if applicable) incur during the grace period (as well as those Incurred during the Plan Year) are subject to the Plan's timely filing provision. Refer to the Timely Filing section of the Claims and Appeal Procedures For Health Care Spending Accounts (Health FSA) provision of this SPD.

In an effort to help make sure that You do not forfeit any unused dollars from the prior Plan Year, during the two-and-a-half month grace period, Your Plan will reimburse You from prior Plan Year dollars first before using the dollars that You elected for the present Plan Year.

Important: If You are enrolled in the Health FSA, do not wait to submit claims for expenses that You and Your Dependents (if applicable) Incurred during the Plan Year. It is important that You submit those claims before a claim for an expense Incurred during the grace period is submitted (automatically) to Your Health FSA and depletes Your dollars from the prior Plan Year. The following example illustrates why it is important to submit expenses Incurred during the Plan Year in a timely manner.

> Joe elected $1,000 for the prior Plan Year. He Incurred $1,000 worth of Medical Care Expenses during the prior Plan Year. As of December 31, however (the end of the prior Plan Year), Joe had submitted and been reimbursed for only $500 worth of the expenses that he Incurred during the prior Plan Year. Therefore, Joe has only $500 remaining in his Health FSA as of the end of the Plan Year. On January 28 (during the two-and-a-half month grace period), Joe incurs a Medical Care Expense of $500 that is submitted to his Health FSA automatically. The Plan pays the $500 claim from Joe's prior Plan Year account balance, which was $500. The account for the prior Plan Year now contains no money. On April 1 (within the timely filing period), Joe submits the remaining $500 of expenses that he Incurred during the prior Plan Year. However, because there is no money in his prior Plan Year account, his claim is denied for insufficient funds. The $500 worth of expenses that Joe waited to submit are no longer reimbursable. (Joe is not permitted to use current Plan Year dollars to reimburse himself for expenses that he Incurred during the prior Plan Year.)

BENEFITS WILL BE PROVIDED BY THE APPLICABLE BENEFIT PLAN / ACCOUNT

The applicable benefit plan or account in which You participate will provide You with the benefits to which You may be entitled under that plan or account. Information regarding those benefit plans and accounts are explained in a separate section of this SPD. (See the Table of Contents.)

ELIGIBILITY AND ENROLLMENT
(Participating in the Plan)

ELIGIBILITY REQUIREMENTS

You are eligible to participate in the Plan if You are a common-law employee under IRS rules and meet the requirements below.

Eligible Employee

An **eligible Employee** will be eligible to participate hereunder as of the date the individual satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. For purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased or temporary Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.
- Self-employed individuals.
- Partners in a partnership.
- 2% or greater shareholders in a Subchapter S corporation.

For purposes of this Plan, eligibility requirements are used only to determine an Employee's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, which may be combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy. The employer's classification of an Employee is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of an Employee's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

EFFECTIVE DATE / ENROLLMENT

An Eligible Employee will become a Participant effective as of the date on which the eligibility and enrollment requirements are satisfied. Your Salary Reduction for elected benefits will be effective the first pay period beginning on or after the Employee's effective date of participation.

New Employees

If You are an Employee who meets the eligibility requirements on the first day of, or during, a Plan Year, You may elect to participate in this Plan for all or the remainder of such Plan Year, provided You elect to do so by returning Your election form within the timeframe established by Your employer, and in no event later than Your effective date of participation. An election form will be provided to You by Your employer. The election form will enable You to elect to participate in the Plan and to authorize the necessary Salary Reductions to pay for the benefits You elect. If You are an eligible Employee and fail to return the election form within the specified timeframe, You will not be permitted to elect to participate in the Plan until the next annual open enrollment period.

Existing Employees

If You are an existing Employee who wishes to continue or to begin to participate (for those Employees who did not elect when first eligible) in the Plan, You must elect to do so during the annual open enrollment period. Each year, during the annual open enrollment period, You will be provided an opportunity to elect to participate in the Plan or to choose not to participate.

ANNUAL OPEN ENROLLMENT PERIOD

If You are an eligible Employee who previously waived coverage under this Plan, including coverage under the Health FSA and the Dependent Care Spending Account, You may apply for coverage during the annual open enrollment period in the form and manner prescribed by the employer. Similarly, if You wish to change Your benefit election(s) under Your Health FSA or Dependent Care Spending Account, You may request the change during the annual open enrollment period as well.

The employer will provide You with a written notice prior to the start of an annual open enrollment period. Your Effective Date of coverage will be January 1 following the annual open enrollment period.

Participation in the following does not carry over into the following Plan Year. You must re-enroll each year in order for Your coverage to be effective.

- Medical Plan
- Health Saving Account
- Health FSA
- Dependent Care FSA

The benefit option(s) You elect will be effective during the Plan Year following open enrollment for as long as You are eligible.

Participation in the following does carry over to the following Plan Year.

- Dental Plan
- Vision Plan

Your contributions will be deducted from Your paycheck beginning with the first pay period in which You are enrolled or the first pay period of the new Plan Year if You enroll during open enrollment.

TERMINATION OF PARTICIPATION

You will cease to be a Participant in the Plan upon the earlier of:

- The expiration of the Plan Year for which You have elected to participate (unless during the annual open enrollment period for the next Plan Year, You elect to continue participating);
- The date of termination of the Plan;
- The end of the month following the date on which You cease (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an eligible Employee;
- The end of the month following the date You revoke Your election to participate due to a qualifying event when such change is permitted under the terms of the Plan; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

The following benefits will terminate as of the date(s) specified in the respective Plans.

- Medical Plan
- Health Saving Account

When You cease to be a Participant in the Plan, Your Salary Reductions will terminate under the Cafeteria Plan, as will Your ability to receive reimbursements from Your Flexible Spending Accounts (FSA's) for expenses Incurred after Your termination, unless otherwise stated within this SPD. For Health FSA's, You may elect to continue Your coverage under COBRA. For more information, refer to "Reimbursements After Termination" in this SPD. For Dependent Care Spending Accounts, You are eligible to spend down Your remaining account balance after termination of employment. You may do so by submitting eligible Dependent Care Expenses that were Incurred until the end of the Plan Year or grace period, if applicable.

However, for Your Health FSA and Your Dependent Care Spending Account, You (or Your estate) may claim reimbursement for any eligible expenses Incurred during the Period of Coverage prior to termination, provided You (or Your estate) file a claim within the timely filing requirements of this Plan. Refer to the Timely Filing section of the Claims and Appeal Procedures For Health Care Spending Accounts (Health FSA) provision of this SPD.

PARTICIPATION FOLLOWING TERMINATION OF EMPLOYMENT

For Flexible Spending Account benefits, if You are a former Participant who is rehired within 30 days or less of the date of a termination of employment, You will be reinstated with the same elections that You had before termination; however, Your coverage will not be reinstated retroactively and Your Salary Reductions will be prorated based on the remaining pay periods in the Plan Year. If You are a former Participant who is rehired more than 30 days following termination of employment and are otherwise eligible to participate in the Plan, You may make a new election as a new hire under this Plan. For any other benefits elected under this Plan, Your participation will be reinstated to the extent provided under the component benefit plan, if permitted by law.

CHANGE IN STATUS
(Permitted Election Changes)

The IRS irrevocability rule generally prohibits mid-year changes to Your elections. However, there are exceptions to this general rule. Because Your contribution is deducted from Your paycheck on a pre-tax basis, the Code regulates when You may enroll, cancel coverage, or make changes to Your elections. Therefore, unless You experience a Change in Status as defined in this SPD, You may not enroll or revoke an election until the next annual open enrollment period.

The change You make must be consistent with the Change in Status rules. The Plan Administrator (in its sole discretion) will determine whether or not a requested change is on account of and corresponds with a Change in Status. The general rule is that a desired election change will be found to be consistent with a Change in Status if the event affects coverage eligibility.

Unless otherwise stated in this SPD, changes to an election must be made within 30 days following the Change in Status event and will become effective the pay period following the date You make the election.

The events that qualify as Changes in Status include those events described below and any other events that the Plan Administrator determines are permitted under subsequent IRS regulations and other guidance. Determinations will be on a uniform and consistent basis in accordance with IRS or other applicable regulations and in accordance with other terms and conditions contained in this SPD.

Unless specifically stated otherwise below, the following permitted events will apply to the component benefit plans offered under this Cafeteria Plan.

An election to make a contribution to an HSA may be increased, decreased, or revoked at any time on a prospective basis in accordance with IRS rules and contribution limits.

CHANGE IN STATUS, INCLUDING LEGAL MARITAL STATUS, NUMBER OF DEPENDENTS, AND DEPENDENT SATISFYING OR CEASING TO SATISFY DEPENDENT REQUIREMENTS

You may revoke an election for the Plan Year and make a new election if You experience any of the following Change in Status events: an event that changes Your marital status (marriage, divorce, annulment or legal separation from a Spouse, or the death of a Spouse), an event that changes the number of Your Dependents (the death, birth, adoption, or Placement for Adoption of a Dependent), or an event that causes Your Dependent to begin to satisfy or cease to satisfy the eligibility requirements for coverage. You may elect to change only an election for the affected person that corresponds with the permitted event. For example:

- the Spouse involved in the divorce, annulment, or legal separation;
- the deceased Spouse or Dependent;
- the Dependent that ceased to satisfy the eligibility requirements; or
- the Dependent that begins to satisfy the eligibility requirements.

Adding or canceling coverage for an individual who is not affected by the permitted event would fail to correspond with that Change in Status. Notwithstanding the foregoing, if You or Your Dependent(s) become eligible for COBRA (or similar Health Plan continuation coverage under state law) under the employer's plan, You may increase Your Salary Reduction election under the Cafeteria Plan to pay for such coverage. (This rule does not apply to a Spouse who becomes eligible for COBRA or similar coverage as a result of divorce.)

HIPAA SPECIAL ENROLLMENT RIGHTS (Does not apply to the Health FSA or Dependent Care Spending Account)

If You and/or Your Dependents acquire special enrollment rights under HIPAA for one of the component benefit plans offered under this Plan, You may revoke Your prior election for group Health Plan coverage for the Plan Year as well as Your Salary Reduction amount and make a new election that corresponds with such enrollment rights, regardless of whether or not the HIPAA special enrollment also qualifies as a Change in Status. As required by HIPAA, a special enrollment right will arise if:

- You or Your Dependent(s) declined to enroll in group Health Plan coverage because You or Your Dependent(s) had other coverage and subsequently eligibility for such other coverage is lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or

- You and/or Your Dependent(s) were covered under a Medicaid plan or state child Health Plan and Your or Your Dependent(s') coverage was terminated due to loss of eligibility. In this instance, You must request coverage for the component benefit plan offered by Your employer under this Flexible Spending Account Plan within 60 days after the date of termination of such coverage; or

- You acquire a new Dependent as a result of:

  - marriage,
  - birth,
  - adoption, or
  - Placement for Adoption.

  If You acquire a new Dependent as a result of birth, adoption, or Placement for Adoption, You may enroll the newly acquired Dependent, as well as Yourself and Your Spouse if You and Your Spouse are not already enrolled in the component benefit plan. In the event of marriage, You may enroll Yourself and Your newly acquired Spouse. You may not enroll any of Your Dependents who were not enrolled.

  Election changes (including Your Salary Reduction election) made on account of a birth, adoption, or Placement for Adoption will be effective retroactively to the date of the event. However, election changes (including Your Salary Reduction election) attributable to marriage will be effective on the first day of the month following the receipt of Your election form by the Plan Administrator.

- You and/or Your Dependent(s) are determined eligible, under a state's Medicaid plan or state child Health Plan, for premium assistance with respect to coverage under a component benefit plan offered by Your employer under this Flexible Spending Plan. You must request coverage for the component benefit plan offered under this Flexible Spending Plan within 60 days after the date You and/or Your Dependent(s) are determined to be eligible for such assistance.

COURT JUDGMENTS, DECREES, AND ORDERS (Does not apply to the Dependent Care Spending Account)

If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires that a plan provided under this Cafeteria Plan provide medical coverage for a Dependent child, You may:

- change Your election to provide coverage for the Dependent child (provided that the Order requires You to provide coverage), or

- change Your election to revoke coverage for the Dependent child if the Order requires that another individual (including Your Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

CHANGE IN EMPLOYMENT STATUS AND GAIN OF COVERAGE ELIGIBILITY UNDER ANOTHER EMPLOYER'S PLAN

You may revoke an election for the Plan Year and make a new election if You or Your Dependent(s) experience an event that results in a change in the employment status of You, Your Spouse, or Your Dependent, including termination or commencement of employment, a strike or lockout, or the commencement of or return from an unpaid leave of absence. If Your request is to cease or decrease coverage as a result of gaining eligibility for coverage under a Cafeteria Plan or qualified benefit plan of Your employer or a Dependent's employer, the Plan Administrator may rely on Your certification that You or Your Dependent(s) have obtained or will obtain coverage under another plan, unless the Plan Administrator has reason to believe that Your certification is incorrect.

CHANGE IN COVERAGE (Does not apply to the Health FSA)

- Significant Curtailment. If coverage is "significantly curtailed" (as defined in first bulleted arrow below) You may elect coverage under another benefit package option that provides similar coverage. In addition, as set forth in second bulleted arrow below, if the coverage curtailment results in a "Loss of Coverage" (as defined in the third bulleted arrow below), You may drop coverage if no similar coverage is offered by the employer. The Plan Administrator, in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether or not a curtailment is "significant," and whether or not a Loss of Coverage has occurred.

  - Significant Curtailment Without Loss of Coverage. If the Plan Administrator determines that Your coverage under a benefit package option under this Plan is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or Health Plan) during a Period of Coverage, You may revoke Your election for the affected coverage, and in lieu thereof, prospectively elect coverage under another benefit package option that provides similar coverage. Coverage under a plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

  - Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that Your selected coverage under the benefit package is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, You may revoke Your election for the affected coverage, and may either prospectively elect coverage under another benefit package option that provides similar coverage or drop coverage if no other benefit package option providing similar coverage is offered by the employer.

  - Loss of Coverage. "Loss of Coverage" means a complete Loss of Coverage (including the elimination of a benefit package option, an HMO ceasing to be available where You reside, or the loss of all coverage under the benefit package option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

    - a substantial decrease in the number of medical care providers available under the benefit package option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of Physicians participating in a Preferred Provider Organization (PPO) or a Health Maintenance Organization (HMO);

    - a reduction in benefits for a specific type of medical condition or treatment with respect to which You are currently in a course of treatment; or

    - any other, similar, fundamental Loss of Coverage.

- *Addition or Significant Improvement of a Benefit Package Option*. If, during a Period of Coverage, the Plan adds a new benefit package option or significantly improves an existing benefit package option, the Plan Administrator may permit the following election changes:

  - If You are enrolled in a benefit package option other than the newly added or significantly improved benefit package option, You may change Your election on a prospective basis and elect the newly added or significantly improved benefit package option; and/or

  - If You are otherwise eligible, You may elect the newly added or significantly improved benefit package option on a prospective basis, subject to the terms and limitations of the benefit package option. The Plan Administrator, in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether there has been an addition of, or a significant improvement in, a benefit package option.

- *Loss of Coverage Under Another Employer's Plan*. You may prospectively change Your election and add group health coverage for a Dependent, if such individual loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program ("SCHIP") under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code §7701 (a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group Health Plan, subject to the terms and limitations of the applicable benefit package option(s).

- Change in Coverage Under Another Employer's Plan. You may make a prospective election change that is on account of and corresponds with a change made under another employer's plan (including a plan of the employer or a plan of the Dependent's employer), as long as:

  - The other Cafeteria Plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations, or

  - The other plan permits its participants to make an election for a Period of Coverage that is different from the Plan Year under this Cafeteria Plan or a qualified benefits plan offered by Your employer. For example, if an election is made by Your Spouse to drop coverage during their employer's open enrollment period, You may add coverage for the Dependent to replace the Dependent's dropped coverage. The Plan Administrator will determine, based on prevailing IRS guidance, whether or not a requested change is on account of and corresponds with a change made under the other employer's plan.

  - If You or Your Spouse is no longer enrolled in a qualified high deductible Health Plan (QHDHP) or elects coverage under a non-QHDHP, You are no longer eligible to contribute to an HSA. After non-QHDHP coverage is elected, You may continue to use Your accumulated HSA balance for Code §213(d) eligible services on a tax-free basis.

CHANGE IN COST (Does not apply to the Health FSA)

For purposes of this section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, a health care flexible spending account (Health FSA) is not similar coverage with respect to an accident or Health Plan that is not a Health FSA. This Plan treats coverage by another employer, such as a Dependent's employer, as similar coverage.

- *Increase or Decrease for Insignificant Cost Changes*. You are required to increase Your elective contributions (by increasing Salary Reductions) to reflect insignificant increases in required contributions for benefit package options, and to decrease Your elective contributions to reflect insignificant decreases in required contributions. The Plan Administrator, in its sole discretion, on a uniform and consistent basis, will determine whether or not an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected Employees' elective contributions on a prospective basis.

- *Significant Cost Increases*. If the Plan Administrator determines that the cost charged to You for a benefit package option significantly increases during a Period of Coverage, You may:

  - Make a corresponding prospective increase to Your elective contributions (by increasing Salary Reductions);

  - Revoke Your election for that coverage, and in lieu thereof, receive, on a prospective basis, coverage under another benefit package option offered by the employer that provides similar coverage; or

  - Drop coverage prospectively if there is no other benefit package option available that provides similar coverage. The Plan Administrator, in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether or not a cost increase is significant.

- *Significant Cost Decreases*. If the Plan Administrator determines that the cost of any benefit package option significantly decreases during a Period of Coverage, the Plan Administrator may permit the following election changes:

  - If You are enrolled in a benefit package option other than the benefit package option that has decreased in cost, You may change Your election on a prospective basis and elect the benefit package option that has decreased in cost; and/or

  - If You are otherwise eligible, You may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option. The Plan Administrator, in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether or not a cost decrease is significant.

FMLA LEAVE (Does not apply to the Dependent Care Spending Account)

If You are on an unpaid leave of absence under the FMLA, You may revoke an existing election for the remaining portion of the Plan Year and make a new election upon returning from such leave, even if coverage terminated during such leave due to the non-payment of any required contributions. You may also enroll in the Plan or change an election while You are on leave in the same manner as an active Employee.

MEDICARE AND MEDICAID (Does not apply to the Dependent Care Spending Account)

If You are a Participant in this Plan and You become enrolled in Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), or You lose such coverage, You may revoke an election under this Plan and make a new election consistent with Your eligibility for Medicare or Medicaid.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (Does not apply to the Health FSA or Dependent Care Spending Account)

- *Reduction In Hours of Service.* If You have been in an employment status under which You were reasonably expected to average at least 30 hours of service per week and there is a change in Your status such that You will no longer average 30 hours of service per week, You may revoke Your election, even if You continue to be eligible to participate in the group Health Plan of Your employer. You and/or Your Dependents must become enrolled in the new plan that provides minimum essential coverage no later than the first day of the second month following the month that includes the date the original coverage was revoked.

- *Enrollment In A Qualified Health Plan.* If You or Your Dependents are eligible, through a special enrollment period, to enroll in a qualified Health Plan through a marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or You or Your Dependents are eligible to enroll in a qualified Health Plan through a marketplace during the marketplace's annual open enrollment period, You may revoke Your prior election, or change from family to individual coverage. You and/or Your Dependents must become enrolled or Your coverage must become effective in the new qualified Health Plan through a marketplace no later than the day immediately following the last day of the original coverage that was revoked.

YOUR FLEXIBLE SPENDING ACCOUNT(S)

If You decide to participate in one or both accounts (a Health FSA and/or a Dependent Care Spending Account), You must select the amount(s) You would like to contribute on a pre-tax basis. Both the Health FSA and the Dependent Care Spending Account are sources of pre-tax funds with which You can reimburse Yourself for Covered Expenses. An account will be set up in Your name in order to keep records of the reimbursements to which You are entitled. These accounts are recordkeeping accounts; they are not funded. (All reimbursements are paid out of the general assets of Your employer.) Your employer is currently bearing the entire cost of administering these accounts, except for amounts forfeited, which may be applied to administrative expenses.

CONTRIBUTION MAXIMUMS / MINIMUMS

Account Type	Contribution Maximum	Contribution Minimum
• Health Care Spending Account	$3,400 per Plan Year	$0
• Dependent Care Spending Account	Up to the maximum IRS amount per Taxable Year (See Dependent Care Spending Account section for further details)	$0

USING YOUR ACCOUNT

If You elect to participate in either the Health FSA or the Dependent Care Spending Account (or both), You must follow these general rules governing their use:

- Funds may not be transferred from a Health FSA to a dependent care FSA.
- Funds may be used only for Covered Expenses, as determined by the claims administrator.
- Funds in excess of the Health FSA carryover amount not used to pay for Covered Expenses Incurred during the applicable coverage period will be forfeited at the end of the claim filing deadline for the coverage period.

IRREVOCABILITY OF YOUR ANNUAL ELECTIONS

Before You decide how much to deposit, carefully estimate Your Medical Care Expenses and Dependent Care Expenses for the year. Since the amount reimbursed to You from Your account is not subject to taxes, the IRS places the following restrictions on Your deposits:

- Once You have made Your election, You may not change the amount of money You contribute to Your account until the beginning of the next Plan Year with the exception of an IRS-permitted event (refer to the Change in Status section for further details).
- Any money that You do not claim for expenses Incurred during the Plan Year or the grace period or through the use of the carryover will be forfeited. These forfeitures are used to offset the administrative expenses of the Plan.

DUPLICATE REIMBURSEMENTS NOT ALLOWED

If You submit a claim to Your Health FSA or Your Dependent Care Spending Account, You may not claim the same expense as a deduction on Your income tax return. If You receive a reimbursement from a third party for expenses already reimbursed by one of Your Flexible Spending Accounts, You will be required to reimburse the Plan for the benefits received.

HEALTH CARE SPENDING ACCOUNT

The Health FSA allows You, as a Participant, to receive benefits in the form of reimbursement for Medical Care Expenses , or for You, as a Participant who contributes to Health Savings Accounts (HSAs), to receive benefits in the form of reimbursement for limited Medical Care Expenses as described below that are intended to be eligible for exclusion from gross income under Code §105(b).

ACCOUNT MINIMUMS

Refer to the Your Flexible Spending Account(s) section of this SPD.

ACCOUNT MAXIMUM

Refer to the Your Flexible Spending Account(s) section of this SPD.

If You and Your Spouse both work for SECUR-SERV, You may each contribute the contribution maximum shown in the Your Flexible Spending Account(s) section to a separate account. You may claim eligible expenses for each covered Dependent once.

UNIFORM COVERAGE

You have immediate access to the total amount of Your annual contribution on the first day of the Plan Year. The uniform coverage rule provides that Your entire annual election may be reimbursed to You for qualified Medical Care Expenses, regardless of the amount actually in Your account at the time.

TAX CONSIDERATIONS

The amount You allocate to this account may be used to reimburse You for any Medical Care Expenses that ordinarily would qualify as medical deductions for federal income tax purposes. However, if You participate in this account, You may not claim any Medical Care Expenses that are reimbursed through this account as deductions on Your federal income tax return since Your taxable income has already been reduced.

If You have any questions or need any assistance, contact Your Human Resources Representative or Your personal tax advisor.

LIMITED MEDICAL CARE EXPENSES (FOR HEALTH SAVINGS ACCOUNT (HSA) PARTICIPANTS)

If You are or will be contributing to a health savings account (HSA) during the Plan Year, You will be eligible to enroll only in the limited-purpose Health FSA option under this Plan for the entire Plan Year. This means that You will be reimbursed only for dental and vision expenses that are eligible under this Plan for the entire Plan Year.

If You are enrolled in the Plan with a grace period, Your benefits during the grace period will remain the same as during the Plan Year.

MEDICAL CARE EXPENSES

The IRS determines what qualifies as a Medical Care Expense. If not specifically excluded, IRS qualified Medical Care Expenses under Code §213(d) are covered by this Plan.

Medical Care Expenses must be Incurred during the Plan Year. With the exception of orthodontia expenses, a Medical Care Expense is Incurred when the service that gives rise to the expense is provided. The date the expense is billed, charged, or paid is irrelevant.

Orthodontia expenses may be reimbursed by this Plan if the expenses have been Incurred within the Period of Coverage. This includes orthodontia expenses that are paid in advance of the services being provided if the advance payment is required in order to receive the services (i.e., a down payment is required). Your orthodontia expenses will be deemed to have been Incurred when You make the advance payment, provided the payment is made within the Period of Coverage.

Orthodontia expenses may also be reimbursed if a reasonable payment schedule or service contract with expense detail is provided with the claim. A reasonable payment schedule or service contract must be prepared by Your dentist and must illustrate what orthodontia services are to be provided, when the services are planned to be provided (identified by month and year), and the corresponding projected expenses associated with those services. An example of a reasonable payment schedule or service contract may include a down payment for initial services provided and subsequent proportional payments in anticipation of follow-up services.

You may not be reimbursed for any expenses arising before the Plan becomes effective, for any expenses arising before Your Salary Reduction agreement becomes effective, for any expenses Incurred after the close of the Plan Year, or for any expenses Incurred after a separation from service (unless You have continuation coverage).

Medical Care Expenses Include Expenses on Behalf of Dependents. Medical Care Expenses include expenses Incurred by Your Spouse or Your Dependent (see the Glossary of Terms) provided the Spouse or Dependent is:

- Your legally recognized Spouse, as long as they are not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a Spouse also includes a Common-Law Marriage Spouse if such partnership is recognized as a legal marriage in the state in which the couple resides. When a person is no longer Your Spouse, that person no longer qualifies as Your Dependent.

- Your child until the end of the taxable year in which they reach their 26th birthday.

- A disabled Dependent child. If You have a Dependent child covered under this Plan who is mentally or physically disabled, that child's health coverage may continue beyond the day the child would cease to be a Dependent under the terms of this Plan as shown in the definition of Dependent. You must submit proof that the child meets these conditions within 31 days after the day coverage would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan may ask for proof not more than once per year. Coverage will continue for as long as they:

    - Are dependent on You and Your Spouse for more than half of their support;

    - Are not able to hold a self-sustaining job due to the mental or physical disability; and

    - Have submitted required proof as described above.

- A Domestic Partner. A Domestic Partner is an unmarried person of the same or opposite sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else. A Domestic Partner affidavit will be required to be completed and filed with the Plan at the time enrollment of the Domestic Partner is requested. In order for Your Domestic Partner to qualify as a Dependent for the purpose of Code §105(b) of the Internal Revenue Code, You and Your partner must complete an affidavit declaring that You and Your partner:

    - Are in a relationship of mutual support, care, and commitment and are responsible for each other’s welfare;

    - Have maintained this relationship for the past six months and intend to do so indefinitely;

- Have shared a primary residence for the past six months and intend to do so indefinitely;

- Are members of the same household. A Domestic Partner will not be considered a "member of the taxpayer's (Employee's) household" if the relationship between the taxpayer (Employee) and the Domestic Partner violates local law;

- Are not married to anyone else and do not have other Domestic Partners;

- Are financially interdependent, which means that the Domestic Partner receives over 50% of their support from the taxpayer (Employee).

MEDICAL VS. PERSONAL EXPENSE

Expenses Incurred for personal reasons only are not reimbursable, according to the IRS. Claims that have been Incurred for medical reasons, but that may also have been for personal reasons, are more closely scrutinized by the IRS than those claims that are obviously for medical reasons only. Massage therapy is an example of such an expense; while there may be a medical reason for such therapy, there may also be a personal reason. Therefore, in a case where there may be both a medical and a personal reason for an expense, the Plan may require additional substantiation for the claim in order to establish the link between the medical condition (or Medical Necessity) and the expense.

Some of the most common Medical Care Expenses that qualify for reimbursement as long as they are not reimbursable from any other source include:

- Cost-sharing of health care coverage, such as deductibles, co-payments, or any other participation in medical expenses.
- Qualified expenses beyond Plan limits.
- Qualified expenses not covered by the Plan.

The following are some examples of Medical Care Expenses:

- Medicine or Medication.
- Dental or medical care outside the scope of a medical or dental plan.
- Vision care outside the scope of a vision plan, including prescription eyeglasses and contact lenses.
- Hearing aids.
- Medical Care Expenses that have not been reimbursed and are not reimbursable from any other source for a Dependent.
- Shipping, handling, and sales tax of eligible expenses.

The following are some examples of limited purpose Health FSA:

- Dental care outside the scope of a dental plan.
- Vision care outside the scope of a vision plan, including prescription eyeglasses and contact lenses.
- Shipping, handling, and sales tax of eligible expenses.

ELIGIBLE MEDICAL CARE EXPENSES UNDER CERTAIN CONDITIONS

The following are some examples of Medical Care Expenses that may be eligible for coverage but require additional substantiation:

- Herbal remedies to treat a specific condition or disease.
- Weight loss drugs or programs to treat a specific condition or disease (including obesity) diagnosed by a Physician.
- Qualified long-term care services or qualified nursing home services.
- Capital expenses.
- Household improvements to treat allergies.
- DNA collection and storage.

- House improvements (e.g., exit ramps, widening doorways).
- Mattresses, recliner chairs, and other furniture.
- Special foods needed to treat a special Illness or ailment, if prescribed by a Physician and if they do not substitute for normal nutritional requirements.

If You are enrolled in a qualified high deductible Health Plan, Your Plan may exclude specific types of Code §213(d) eligible expenses. See the Limited Medical Care Expenses section in this SPD.

PLAN EXCLUSIONS

The following items are not considered Medical Care Expenses under the IRS Code or this Plan:

- Drugs obtained in an illegal manner.
- Controlled substances if such substances violate federal law, even if prescribed by a Physician.
- Vitamins or dietary nutritional supplements available without a prescription, even if prescribed by a Physician.
- Health insurance premiums that You or Your Spouse pay for coverage under another Health Plan.
- Insurance premiums generally.
- Cosmetic Surgery or other similar procedures, unless the surgery or procedures are necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified Physician due to Your or Your Dependent's inability to perform physical housework).
- Custodial care.
- Massage therapy, unless prescribed by a Physician to treat a specific injury or trauma.
- Costs for sending a child to a special school for benefits the child may receive from the course of study and disciplinary methods.
- Health club dues with respect to general membership.
- Weight loss drugs or programs, unless for a specified disease diagnosed by a Physician such as obesity, heart disease, or diabetes.
- Social activities, such as dance lessons, even if recommended by a qualified Physician for general health improvement.
- Swimming lessons, even if recommended by a Physician for general health improvement
- Maternity clothes.
- Diaper services or diapers.
- Uniforms or special clothing, such as maternity clothing.
- Transportation expenses not primarily for and essential to medical care.
- Home or automobile improvements or other similar capital expenses to the extent that they appreciate the value of personal assets.
- Any expense that does not qualify under Code §213(d).
- Teeth bleaching.
- Exercise equipment or programs unless prescribed by a Physician to treat a specific medical condition.

OVER-THE-COUNTER DRUGS/ITEMS

ELIGIBLE OVER-THE-COUNTER DRUGS

Eligible over-the-counter (OTC) drugs include Medicines that alleviate or treat injuries or sicknesses. They are not cosmetic in nature nor merely beneficial to a Covered Person's general health. They include such items as antacids, allergy Medicines, pain relievers, cold Medicines, and other qualified Code §213(d) Medical Care Expenses.

ELIGIBLE OVER-THE-COUNTER ITEMS

Eligible OTC items include any items that alleviate or treat injuries or sicknesses. They are not cosmetic in nature nor merely beneficial to a Covered Person's general health. They include such items as home pregnancy tests, durable medical equipment, band aids, menstrual products, contact lenses, cold packs, and Ace bandages.

INELIGIBLE OVER-THE-COUNTER DRUGS

Ineligible OTC drugs/items are those that are merely beneficial to general health, including toiletries, Cosmetics, and vitamins or dietary supplements, as well as other Medical Care Expenses that are not qualified under Code §213(d).

DUAL-PURPOSE OVER-THE-COUNTER DRUGS/ITEMS

Some OTC drugs/items have medical purposes *and* cosmetic or general health purposes. These items are referred to as "dual-purpose" drugs/items. A request for reimbursement of a dual-purpose expense requires a Physician's diagnosis of a medical condition, and a signed statement by a Physician.

IMPORTANT INFORMATION ABOUT THE ABOVE EXPLANATIONS

Eligibility of OTC expenses will be determined according to IRS Code §213(d) as interpreted by the Plan Administrator in its discretion. Discretionary authority of the Plan Administrator is described in this SPD in the Plan Information and the Recordkeeping and Administration sections.

LIMITATIONS ON REIMBURSEMENT OF OVER-THE-COUNTER DRUGS/ITEMS

You will be reimbursed only for a reasonable quantity of an eligible OTC Medical Care Expense as determined by the Plan Administrator. (For example, 25 bottles of aspirin in one month would not be considered reasonable.)

SUBMITTING CLAIMS FOR OVER-THE-COUNTER DRUGS/ITEMS

You must submit a signed claim form along with the receipt for each claim. The receipt for any Over-the-Counter Drugs/Items must include the following information:

- Merchant name
- Description of the Over-the-Counter Drugs/Items
- Date purchased
- Amount paid

Reminder: Any claim that You submit must be for You or an eligible Dependent. Any attempt to submit unqualified claims constitutes fraud. Fraud by a Participant is described in this SPD in the Fraud section.

If You are enrolled in a qualified high deductible Health Plan, Your Plan may exclude specific types of Code §213(d) eligible Over-the-Counter expenses. See the Limited Medical Care Expenses section in this SPD.

CLAIMS AND APPEAL PROCEDURES FOR HEALTH CARE SPENDING ACCOUNTS (Health FSAs)

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claim determinations are made in accordance with the applicable legal requirements. The Plan provisions will be applied consistently with respect to similarly situated individuals.

TIMELY FILING

All claims must be submitted for reimbursement on or before March 31 of the year following the year in which the expenses were Incurred. You will forfeit any amount in excess of the Health FSA carryover amount remaining in Your account. See the prior explanation of the "use-or-lose rule."

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. The Covered Person should contact the Plan Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official. When Health FSA claims are submitted to the Plan by a Personal Representative, it will be assumed that the Personal Representative is acting as the Personal Representative of the Participant.

PROCEDURES FOR SUBMITTING CLAIMS

Claims may be submitted as Covered Expenses are Incurred during the Plan Year. Your Plan Year is the 12-month period beginning on January 1. You will be reimbursed for eligible flexible spending account expenses as long as the amount requested is at least $10 and the amount does not exceed the limit of Your elections for the year, including any prior withdrawals and any availability restrictions. The $10 minimum claim requirement will be waived at the end of each month to ensure that You receive the tax benefit of all Covered Expenses, up to Your contribution limit for the year.

If You or Your Dependent receives services in a country other than the United States, You will be reimbursed for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date of service.

In order to have Your claims processed as soon as possible, please read the claim instructions found on the flexible spending account claims form.

SUBMITTING HEALTH CARE CLAIMS

Under this Plan, You have several options for seeking reimbursement for Your Medical Care Expenses. You may submit the claim either on an FSA claim form or through Your Plan Sponsor's healthcare website or FSA mobile application, or You may seek reimbursement by using Your debit card or auto reimbursement, if either of these options is offered by Your employer.

Flexible spending accounts claim forms are available at www.umr.com, through Your Human Resources Department, or by calling 1-800-826-9781 toll-free. You must submit a claim form for each claim You submit.

Whether You submit Your claim on an FSA claim form or through Your Plan Sponsor's healthcare website or FSA mobile application, You must include the following information:

- A written statement or bill from an independent third party, namely:
  - A statement, bill, or receipt from a medical professional (e.g., Physician or pharmacist) or Merchant, or
  - An Explanation of Benefits (EOB).
- The amount of the medical expense.
- An identification or description of the medical expense, minus the amount reimbursable from any other source, if applicable.
- The date that the medical expense was Incurred.

Please note that it is not necessary for You to have actually paid an amount due for a Covered Expense. You need only to have Incurred the expense. You must also attest to the fact that the expense is not being paid for or reimbursed from any other source. Claim forms, Your Plan Sponsor's healthcare website, and the FSA mobile application will contain this information.

If You have paid the contributions for the coverage You have elected, You will be reimbursed for Your Covered Expenses within 30 calendar days after You submit Your claim. You will be notified in writing if any claim for benefits is denied.

Debit Card

The debit card provides You with an automated way to pay for Your qualified expenses. You may access the pre-tax contributions You set aside in Your FSA electronically. Each time You incur a qualified expense at an eligible location as defined by the eligible services on Your debit card and that location accepts MasterCard®, You may use Your debit card. The amount of Your qualified purchases will be deducted from Your FSA automatically.

Do not use Your debit card at locations that are not related to health care or dependent care, such as restaurants, gas stations, or bookstores. In addition, You may use Your debit card to purchase OTC drugs. It is important for You to save itemized receipts whenever You use the card.

The IRS requires that all expenses paid from the FSA be substantiated. Co-pay matching, recurring expense logic, real-time substantiation, and an inventory information approval system (IIAS) are all permissible methods of substantiation. The Participant must provide information from a third party (such as an itemized receipt or explanation of benefits) as substantiation for all unsubstantiated expenses. Therefore, be prepared to submit Your receipts as proof of eligibility for each transaction. In other words, be certain the transaction is for an eligible expense.

You must repay any improper payments that are made with Your debit card. Improper payments may be recouped in accordance with applicable IRS guidance.

NOTIFICATION OF BENEFIT DETERMINATION

Each time You submit a claim, You will receive a written Explanation of Benefits (EOB) form that will explain how much was paid toward the claim or that the claim was denied. If You have any questions or concerns about the EOB, call UMR at the number listed on the form.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

The Plan will process Your claim within 30 calendar days following receipt of a claim request, but the Plan may have an additional 15-day extension when necessary for reasons beyond control of the Plan, if written notice is provided to You within the original 30-day period.

A claim is considered to be filed when a complete claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- Your loss of eligibility for coverage under the Health Plan.
- Charges are Incurred prior to Your Effective Date or following termination of coverage.
- You or Your Dependents reached the maximum benefits under the Health FSA.
- Amendment of the group flexible benefits Plan.
- Termination of the group flexible benefits Plan.
- You did not respond to a request for additional information needed to process the claim or appeal.
- Services are not considered medical in nature.
- Services are not covered under this Plan.
- Misuse of the Plan or other fraud.
- Failure to pay required contributions.
- Your claim submission was incomplete.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make Payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make Payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, You will receive an initial claim denial notice within the timelines described above. A claim denial notice, usually referred to as an EOB, will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or their Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.

- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or their Personal Representative must submit a written request for a second review within 60 calendar days following the date they received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.

- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on their rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan. Refer to the Statement of ERISA Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under Section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Appeal Request forms are available at www.umr.com to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, a Covered Person has the right to further appeal an Adverse Benefit Determination by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section of this SPD for more details. **No such action may be filed against the Plan later than three years from the date the Plan gives the Covered Person a final determination on their appeal.**

HEALTH CARE SPENDING ACCOUNT COMPLIANCE WITH ERISA AND LAWS APPLICABLE TO GROUP HEALTH PLANS

LAWS APPLICABLE TO GROUP HEALTH PLANS

In the event that the IRS issues further guidance this Plan will be administered according to that guidance.

Benefits under the Health FSA will be provided in compliance with the federal laws, including the following laws, to the extent that such laws are applicable to the Health FSA and the Health FSA is not otherwise exempt:

- Employee Retirement Income Security Act (ERISA).
- Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Family and Medical Leave Act (FMLA).
- Uniformed Services Employment and Reemployment Rights Act (USERRA).
- Medicare Secondary Payer law, as amended.

COORDINATION OF BENEFITS

Health FSAs are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA is not considered a group Health Plan for coordination of benefits purposes, and will not be taken into account when determining benefits payable under any other group Health Plan or policy of insurance.

REIMBURSEMENTS AFTER TERMINATION

When You cease to be a Participant under the Health FSA, Your Salary Reductions will terminate. You will not be able to receive reimbursements under the Health FSA for expenses Incurred after Your participation terminates.

However, You may be able to elect to continue Your coverage under the continuation of coverage provisions of COBRA, as stated below. In addition, You (or Your estate) may claim reimbursement under the Health FSA for any expenses Incurred during the Period of Coverage prior to termination, provided You (or Your estate) file a claim within the timely filing requirements of this Plan. Refer to the Timely Filing section of the Claims and Appeal Procedures For Health Care Spending Accounts (Health FSA) provision of this SPD.

COBRA (Continuation Coverage for Health FSA Benefits)

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You and Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group Health Plan for which You are eligible (such as a Spouse's plan), even if that plan generally does not accept Late Enrollees.

Continuation coverage refers to Your right, or Your Spouse's or Dependents' right, to continue the same coverage under the Health FSA that was in place the day before a Qualifying Event if participation by You (including Your Spouse and Dependents) otherwise would end due to the occurrence of the Qualifying Event.

The COBRA Administrator for this Plan is: UMR

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits (including health care spending account benefits) beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active Participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered Spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group Health Plan or is enrolled in Medicare at the time of the COBRA election.

A **Qualifying Event** is:

- Termination of Your employment (other than by reason of gross misconduct) or reduction of Your work hours;
- Your death;
- Divorce or legal separation from Your Spouse;
- Your becoming entitled to receive Medicare benefits; or
- Your Dependent no longer qualifying as a Dependent.

A **Qualified Beneficiary** is a person covered by the Health FSA the day before the Qualifying Event who is:

- The Employee; or
- The Spouse of a covered Employee; or
- The Dependent child of a covered Employee. This includes a child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrator, whether to Your employer or to the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request):

- The Qualified Beneficiary's name, current address, and complete phone number,
- The group number and the name of the Employee's employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

Send all notices or other information required by this Summary Plan Description in writing to:

UMR
COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206
Phone Number: (800) 207-1824

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to the Employee's termination of employment or reduction in hours, the death of the Employee, or the Employee's becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the Employee and a Spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, the covered Employee, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE HEALTH CARE FLEXIBLE SPENDING COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that they must complete in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing or via the online portal, if available, in order to continue group health coverage and must make the required payments when due in order to remain covered. If online election is available, You will receive instructions for online election when Your election notice is provided. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

ELIGIBILITY FOR COBRA

Only those Participants with positive Health FSA balances will be eligible for COBRA continuation coverage. However, even if COBRA is offered for the year in which the Qualifying Event occurs, COBRA coverage for the Health FSA will cease at the end of the year and will not be continued for the next Plan Year. You may pay premiums for such coverage on an after-tax basis, but not beyond the current Plan Year.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, health care flexible spending coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes the waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

You will be required to pay the entire cost of continuation coverage. The cost of Your coverage under the Health FSA will be based on the balance of Your Health FSA and the number of months remaining in the Plan Year. This cost may also include a 2% additional fee to cover administrative expenses.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope or, if online election is available, the date Your election is submitted electronically. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular Period of Coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will notify You and allow You 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, the occurrence will be treated as non-payment and the Qualified Beneficiary(ies) will lose coverage under the Plan in accordance with the Plan language above.

NOTE: Payment will not be considered made if a check is returned for non-sufficient funds.

LENGTH OF CONTINUATION COVERAGE

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Covered Person whose coverage terminates under the Health FSA because of a COBRA Qualifying Event will be given the opportunity to continue coverage under the Health FSA on an after-tax basis for the remainder of the Plan Year. Coverage may not be continued for the next Plan Year.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group Health Plan coverage (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if You do not enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period You have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after Your employment ends, or (b) the month after group Health Plan coverage based on current employment ends.

If You do not enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage. If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA continuation coverage will pay second. For more information visit https://www.medicare.gov/medicare-and-you.

EARLY TERMINATION OF COBRA CONTINUATION

Continuation coverage under COBRA may terminate before the end of the year for any of the following reasons:

- The employer ceases to maintain a group Health Plan for any Employees. (Note that if the employer terminates the group Health Plan under which the Qualified Beneficiary is covered, but still maintains another group Health Plan for other, similarly situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group Health Plan, although benefits and costs may not be the same);

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations;

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare;

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group Health Plan;

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose their special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with their HIPAA special enrollment rights.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, and for more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group Health Plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

The Plan Administrator:
SECUR-SERV
2020 S 156TH CIR
OMAHA NE 68130

The COBRA Administrator:
UMR COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Health Benefits. Despite any provision to the contrary in this Plan, if You are absent from work due to qualifying leave under the FMLA, then to the extent required by the FMLA, the employer will continue to maintain Your health benefits and Health FSA on the same terms and conditions as if You were still an active Employee. Therefore, if You elect to continue Your coverage while on leave, the employer will continue to pay its share of the contribution.

You may elect to continue Your coverage under the Health FSA during the FMLA leave. If You elect to continue Your coverage while on leave, then You may pay Your share of the contribution in one of the following ways:

- *Pay-as-You-go* with after-tax dollars by sending monthly payments to Your employer or on a pre-tax basis to the extent the contributions are made from taxable Compensation (e.g., from unused sick days or vacation days) that You accrue during the leave;*Pre-pay* with pre-tax dollars by pre-paying all or a portion of the contribution for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation or on a pre-tax basis to the extent the contributions are made from taxable Compensation (e.g., from unused sick days or vacation days) that You accrue during the leave. In order to pre-pay the contribution, You must make a special election to that effect prior to the date such Compensation would normally be made available to You. Pre-tax dollars may not be used to fund coverage during the next Plan Year. In addition, contributions may also be made on an after-tax basis under this option; or
- *Catch-up* the contributions due to the Plan Administrator under an arrangement agreed upon between You and the Plan Administrator (i.e., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts upon Your return).

If Your coverage ceases while You are on FMLA leave, You will be permitted to re-enter the Plan upon return from such leave on the same basis as when You were participating in the Plan prior to the leave. You may either resume coverage at Your original level and make up the unpaid contributions or resume coverage at a reduced level under the proration rule and resume contributions at Your original contribution level.

NON-FMLA LEAVES OF ABSENCE

If You are absent from work due to an unpaid leave of absence that does not affect eligibility, You will continue to participate in the Plan and any contribution due will be paid for with one of the following options: pre-payment before going on leave, pay-as-You-go with after-tax contributions while on leave, or catch-up contributions after leave ends, as determined by the Plan Administrator.

If You go on an unpaid leave that affects eligibility, the election change rules described in this SPD will apply. To the extent COBRA applies, You and Your Dependents may continue coverage under COBRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or on furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to waiting periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which their service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the "COBRA" section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount they would have paid as an active Employee. If an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER PRIVACY AND SECURITY REGULATIONS

This Plan will Use Your Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose Your PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose Your PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share Your PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of Your PHI. See the Glossary of Terms section of this SPD for the definitions of terms used in this provision.

This Plan will Disclose Your PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations. Any Disclosure of PHI to the Plan Sponsor will be made only upon receipt of a certification from the Plan Sponsor that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor will Use and/or Disclose Your PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan and is subject to all of the following:

- The Plan Sponsor will Use and Disclose Your PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. Your Plan's Notice of Privacy Practices contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide Your PHI (including Electronic PHI) to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to Your PHI and to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor will allow You or this Plan to inspect and copy any PHI about You contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that You and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of Your PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. You have the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of Your PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all Your PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs Your PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If such return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that Your PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of Your PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to Your PHI for Plan administrative functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Human Resources

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive Your PHI. If any of these Employees or workforce members Use or Disclose Your PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to You.

STATEMENT OF ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) applies to the Health FSA but not to the Dependent Care Spending Account. As a Health FSA Participant, You are entitled to certain rights and protections under ERISA. ERISA provides that You and Your Dependents have the right to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls) all documents governing the Health FSA, including collective bargaining agreements, if applicable, and a copy of the latest annual report (Form 5500 series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Health FSA, including collective bargaining agreements, if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

CONTINUE HEALTH FSA BENEFITS

You may continue Health FSA benefits for Yourself, Your Spouse, and Your Dependents if You experience a loss of coverage under the Plan as a result of a COBRA Qualifying Event. You or Your Dependents may have to pay for such benefits. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for You and Your Dependents, ERISA imposes duties upon the people who are responsible for the operation of the Health FSA. The people who operate the Health FSA, known as "fiduciaries," have a duty to do so prudently and in the interest of You and all Participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You in any way to prevent You from obtaining a benefit or exercising Your rights under ERISA.

ENFORCE YOUR RIGHTS

If Your claim for a benefit under the Health FSA is denied, in whole or in part, You have a right to know why this was done, to obtain copies of documents related to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of the Plan documents or the latest annual report from the Health FSA plan and You do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 per day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in state and federal court. If it should happen that the Health FSA's fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees (for example, if it finds Your claim to be frivolous).

ASSISTANCE WITH YOUR QUESTIONS

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

DEPENDENT CARE SPENDING ACCOUNT

The Dependent Care Spending Account is provided to allow You to receive benefits in the form of reimbursements for Eligible Employment-Related Expenses Incurred on behalf of a Dependent. The Dependent Care Expenses reimbursed are intended to be eligible for exclusion from gross income under Code §129(a).

ACCOUNT MINIMUMS

Refer to the Your Flexible Spending Account(s) section of this SPD.

ACCOUNT MAXIMUM

You may contribute up to the maximum IRS amount, subject to the limitations set forth under "Maximum Reimbursement Available."

You may not be reimbursed in excess of the contributions You have made at any point in time. Once You incur Covered Expenses, You may file a claim and be reimbursed for up to the maximum amount of Your account balance.

MAXIMUM REIMBURSEMENT AVAILABLE (Calculated on a per-taxable-year basis)

You may contribute up to the *least* of the following amounts:

- The year-to-date amount that has been withheld from Your Compensation for the Dependent Care Spending Account for the Period of Coverage, less any prior reimbursements for Dependent Care Expenses during the Period of Coverage;
- Your Earned Income for the applicable month;
- Your Spouse's Earned Income for the applicable month;
- The following annual amount:
  - $7,500, if one of the following applies:
    - You are married and file a joint return;
    - You are married, but furnish more than one-half of the cost of maintaining the Dependent for whom You are eligible to receive reimbursements under the Dependent Care Spending Account, Your Spouse maintains a separate residence for the last six months of the calendar year, and You file a separate tax return; or
    - You are single or the head of the household for federal tax purposes.
  - $3,750, if You are married but You and Your Spouse file separate tax returns.
  - Your taxable Compensation (after Your Salary Reduction under the applicable benefit Plan).
  - Your Spouse's actual or deemed Earned Income.

If You are married, but Your Spouse has no Earned Income, then You are deemed to have an Earned Income of $250 per month ($500 per month if You have two or more Dependents) in each month during which Your Spouse was:

- a Full-Time Student at an educational organization during at least part of five calendar months during the calendar year; or

- incapable of self-care due to a mental or physical condition.

If Your Spouse has a Dependent Care Spending Account through their employer, Your combined contribution may not be more than $7,500. If You and Your Spouse both work for the same employer You may both contribute to the account, but may not contribute more than $7,500 combined.

TAX CONSIDERATIONS

The monies that You receive as Dependent Care Expenses under this flexible spending account generally are not subject to Social Security (FICA) taxes, federal taxes, or, where applicable, state or local income taxes. However, they are reported on Your W-2 form. This reporting is required by the IRS in order to ensure that taxpayers do not claim the same expenses in two places. If You are using both the tax credit and the Dependent Care Spending Account, You must reduce the amount of Dependent Care Expenses that qualify for the tax credit by the amount You received from the pre-tax Dependent Care Spending Account.

Determine whether it is more beneficial for You to use the Dependent Care Spending Account or the federal income tax credit for these expenses. You may wish to consult Your personal tax advisor. The actual determination of the preferable method for treating benefit payments depends upon a number of factors such as Your tax filing status (e.g., married, single, head of household) and the number of Dependents. You will have to determine Your individual tax position in order to make a decision between taxable and tax-free benefits.

You may not claim any other tax benefit for the pre-tax amounts You receive under this Dependent Care Spending Account, although the balance of Your Dependent Care Expenses may be eligible for the Dependent care credit.

IRREVOCABILITY RULE

Your election to participate in the account(s) is irrevocable for the duration of the Plan Year except as permitted when You experience a Change in Status. In the event of a Change in Status:

> You are not allowed to reduce Your election for Dependent Care Spending Account benefits to a point where the annualized contribution for such benefit is less than the amount already reimbursed.

In addition, any change in an election affecting the Dependent Care Spending Account pursuant to this section will also change the maximum reimbursement benefit for the Period of Coverage remaining in the Plan Year. The maximum reimbursement benefit following an election change is calculated as follows:

> Balance (if any) remaining in Your reimbursement account as of the end of the portion of the Plan Year immediately preceding the change in election
>
> \+ Total contributions You scheduled to make for the remainder of the Plan Year as affected by the election change
>
> Maximum reimbursement benefit for Period of Coverage remaining in the Plan Year

DEPENDENT CARE EXPENSES IN GENERAL

These expenses must meet all of the following conditions in order for them to be Eligible Dependent Care Expenses that qualify under Code §21:

- The expenses are Incurred for services rendered after the date of Your election to receive reimbursements for Dependent Care Expenses, and during the coverage period to which they apply.
- Each individual for whom You incur the expenses is a Dependent under the age of 13 for whom You are entitled to a personal tax exemption as a Dependent, or a Spouse or other tax Dependent who is physically or mentally incapable of caring for himself or herself.
- The expenses are Incurred for the care of a Dependent, or for related household services, and are Incurred to enable You to be gainfully employed.
- If the expenses are Incurred for services outside Your household and for the care of a Spouse or other Dependent age 13 or older who is Incapable of Self-Care, such individual regularly spends at least eight hours per day in Your home.
- 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.
- 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 or an individual for whom You or Your Spouse is entitled to a personal tax exemption as a Dependent.

Here are some examples of Dependent Care Expenses:

- Nursery schools. (The entire cost may be treated as Dependent Care Expenses only if the amount paid for schooling is incidental to, and cannot be separated from, the cost of care.)
- Day care centers.
- Day care in Your home.
- Licensed day care centers for children or adults.
- Before- or after-school programs.

EXCLUSIONS

The following are examples of expenses that do not qualify for reimbursement from Your Dependent Care Spending Account:

- Payments to Your child who is under age 19 and who is caring for a younger child.
- Tuition expenses for schooling in kindergarten or higher grade levels.
- Food or clothing expenses.
- Overnight camp expenses.
- Summer school.
- Tutoring programs.
- Expenses in excess of Your taxable income or that of Your Spouse, whichever is less.
- Expenses Incurred when You are not working.
- Expenses Incurred prior to the coverage date or after the Plan Year ends.
- Expenses claimed as a deduction or credit for federal or state tax purposes.
- Other expenses that do not fall within IRS guidelines.
- Expenses Incurred if Your Spouse is not engaged in gainful employment during the hours Dependent Care is needed and the Spouse is not physically or mentally disabled or otherwise incapable of caring for a Dependent(s).
- Any expenses that do not qualify under Code §21.

FUNDING

When You complete the Salary Reduction agreement, You specify the amount of Dependent Care Spending Account benefits for which You wish to pay with Your Salary Reduction. Thereafter, Your Dependent Care Spending Account will be credited with the portion of Your gross income that You have elected to forgo through Salary Reduction. These portions will be credited each pay period. The amount that is available for reimbursements at any particular time will be whatever has been credited to Your Dependent Care Spending Account as of the date of processing of the request for reimbursement, less any reimbursements already paid.

For example, You have elected to be reimbursed for $2,600 per year for Dependent Care Expenses. Your Dependent Care Spending Account would be credited (and funded) with a total of $2,600 during the Plan Year. Thus, if You are paid biweekly, You would have a total of $100 credited to Your Dependent Care Spending Account each payday to pay reimbursements under this Plan.

You may not be reimbursed for any expenses arising before the Dependent Care Spending Account becomes effective, before Your Salary Reduction agreement becomes effective, after the close of the Plan Year, or after a separation from service, unless otherwise specified within this SPD.

SUBMITTING DEPENDENT CARE CLAIMS

When You incur an expense that is eligible for Payment, submit a claim to UMR through Your Plan Sponsor's healthcare website, through the FSA mobile application, or on a paper claim form supplied to You. You must submit a written statement from an independent third party (the qualified caregiver) indicating their tax identification number or Social Security number, the date the services were provided, and the amount of the expense. This documentation will fulfill the claims substantiation requirements by the IRS.

If enough contributions have been made to the Dependent Care Spending Account, You will be reimbursed for Your Covered Expenses within 30 days.

If Your claim is for an amount that exceeds Your current account balance, the excess part of the claim will be carried over into following months, to be paid as Your balance becomes adequate to cover the unpaid portion of the expense. Please note that it is not necessary for You to have actually paid an amount due for a Covered Expense. You need only to have Incurred the expense. You must also attest to the fact that the expense is not being paid for or reimbursed from any other source. Claim forms will contain this information.

SPEND DOWN RULE

You are eligible to spend down Your remaining account balance after termination of employment. You may do so by submitting eligible Dependent Care Expenses that were Incurred prior to termination or after termination until the end of the Plan Year or grace period, if applicable.

TIMELY FILING

You will have 90 days after the end of the Plan Year to submit a claim for reimbursement for a Covered Expense Incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied. To appeal a denial of a Dependent care claim, follow the same appeal process listed in the Appeals Procedure for Adverse Benefit Determinations section under Claims and Appeal Procedures for Health Care Spending Accounts.

PARKING AND TRANSPORTATION SPENDING ACCOUNT
(also referred to as a Commuter Reimbursement Account)

Parking and transportation benefits are separate from Code §125 benefits. This section is intended to qualify as a "qualified transportation fringe" benefit plan under Code§132(f) and applicable regulations. You may have up to $340 per month for parking and/or $340 per month for vanpooling and transit pass expenses credited to Your Parking and Transportation Spending Account. These allowed expenses total a maximum annual Salary Reduction of $8,160. The covered parking and transportation expenses may be adjusted each year for inflation. Your Plan Sponsor establishes a monthly coverage period and reserves the right to change the maximum election amounts as needed.

Plan the amount of Your Salary Reduction carefully because elections are irrevocable. You may not receive any refund of unused Salary Reductions from Your transportation account upon loss of eligibility under this Plan.

WHAT IS COVERED

IRS guidelines currently determine the types of parking and transportation expenses that are eligible for reimbursement through the Parking and Transportation Spending Account. Covered Expenses are:

- Expenses for parking on or near Your work location that You incur for Your own vehicle or as a member of a car pool.
- Expenses for parking on or near a location from which You commute to work by mass transit or a Commuter Highway Vehicle.
- Expenses for purchase of a mass transit pass or voucher (e.g., for a bus or commuter train).
- Expenses for transportation in a Commuter Highway Vehicle.

NOTE FOR TRANSIT PASS BENEFITS

A cash reimbursement or a debit card program may be provided for Your transit expenses only if no voucher is readily available for direct distribution by the employer, as defined under IRS rules.

NOTE FOR CAR POOLERS

Only <u>one</u> member of a car pool may collect pre-tax reimbursement for parking or transportation expenses from this Plan or any other employer's parking and transportation spending account program. If You are a member of a car pool, You will need to agree with the other members on which person will participate in a plan of this type.

WHAT IS NOT COVERED

According to current guidelines, expenses that are not eligible for reimbursement from a Parking and Transportation Spending Account include:

- Gasoline and mileage expenses for Your personal vehicle or a vehicle used in a car pool.
- Parking and/or transportation expenses for a Spouse or other Dependent.

Guidelines governing eligible and ineligible expenses for pre-tax spending accounts have changed in the past and may change again in the future. If IRS regulations change any provisions in the current guidelines, the administration of the Plan provisions must also change accordingly.

SUBMITTING PARKING AND TRANSPORTATION ACCOUNT CLAIMS

In order to submit a claim, complete a Parking and Transportation Spending Account claim form online, through the Consumer Account with UMR mobile application, or on paper and send it to the address listed on the form. Claim forms can be obtained through Your Plan Sponsor's healthcare website or Your Human Resources Department.

Claims must be submitted no later than March 31 following the end of the calendar year in which the expenses were Incurred or 180 days following the date on which the expenses were Incurred, if earlier. Claims submitted after that date will not be considered for reimbursement.

An eligible expense is "Incurred" on the date a service is rendered, not on the date You receive or pay the bill. Any claim You submit for reimbursement must be for at least $0, although Your last claim for any month or the end of the Plan Year may be for less.

PROPER DOCUMENTS

You will need documentation of Your eligible parking and transportation expenses (a receipt, invoice, or payment voucher that shows the date, provider, and type of service).

RECEIVING YOUR REIMBURSEMENT

You may be reimbursed only up to the amount already credited to Your Parking and Transportation Spending Account at the time You submit an expense. Any eligible expense that exceeds Your account balance will be reimbursed to You when Your account balance meets or exceeds the expense.

An explanation of the Parking and Transportation Spending Account Payment will be included with Your reimbursement check.

Your claim will not be reimbursed if:

- Charges are Incurred prior to Your Effective Date or following termination of coverage.
- The service is for Your Dependent.
- The service claimed is not an eligible expense.
- The required documentation is not provided.
- The claim is not submitted by the appropriate deadline.
- The claim form is improperly completed.

DEBIT CARD

The debit card provides You with an automatic way to pay for Your qualified parking or transportation expenses. You may electronically access the pre-tax or post-tax contributions (as determined by Your employer) You set aside in the Parking and Transportation Spending Account. Each time You incur a qualified parking or transportation expense at an approved location that accepts MasterCard®, You may use Your debit card. The amount of Your qualified purchases will be deducted from Your Parking and Transportation Spending Account automatically.

The card may be used at eligible merchants up to the pre-tax contribution amount, but not to exceed the monthly IRS maximums. If post-tax contributions are a benefit offered by Your employer, then eligible expenses over the monthly IRS maximum may be paid with post-tax funds.

Do not use Your debit card at locations that are not parking- or transportation-related, such as restaurants, gas stations, or bookstores. The IRS requires that all card transactions be substantiated by the Plan. If You use Your debit card, the transaction may be automatically substantiated and You will not need to provide documentation to the Plan; however, it is important that You keep all receipts.

If You have a health care or dependent care account as well, please refer to the applicable plan document for information regarding the debit card for each of those accounts.

YOUR CERTIFICATION

The benefit of using a flexible spending account is that You receive pre-tax dollars for qualified expenses. In this way, a flexible spending account alters Your income tax liability, for which You are solely responsible. UMR and this Plan are not liable for any penalties or damages as a result of an inappropriate claim being filed.

There are rules that You must follow under the terms of this Plan, which are set forth in the following certification. This certification can be found on the claim form so that each time You submit a claim, You can refer to the rules that You must follow when submitting claims to Your flexible spending account.

I certify that the expenses for which I am requesting reimbursement meet all of the conditions listed below:

- They were Incurred for services or supplies received by me or my eligible Dependents under the Plan.
- They were for services and/or supplies furnished on or after the Effective Date of my Health FSA and/or Dependent Care Spending Account.
- I have not been reimbursed for these expenses in any other way or from any other source.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all Plans under which my eligible Dependents and I are covered.

I further certify that I have not deducted, nor will I deduct, on my individual income tax return any of the expenses reimbursed through my Health FSA and/or Dependent Care Spending Account. I understand that reimbursement will be made in accordance with the provisions of the Health FSA and/or Dependent Care Spending Account plan. I accept responsibility for the proper treatment of benefits paid under this Plan with respect to eligibility, income tax reporting, and liability.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's Spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on their knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under their identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. They should answer all questions to the best of their knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

RECORDKEEPING AND ADMINISTRATION

PLAN ADMINISTRATOR

The administration of this Plan is under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is administered, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

POWERS OF THE PLAN ADMINISTRATOR

The Plan Administrator has such duties and powers as it considers necessary or appropriate to discharge its duties. It has the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder will be conclusive and binding upon all persons. Without limiting the generality of the foregoing, the Plan Administrator has the following discretionary authority:

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions related to eligibility and participation, and questions of benefits under this Plan to prescribe procedures to be followed and the forms to be used to make elections pursuant to this Plan;
- To prepare and distribute information explaining this Plan and the benefits under this Plan in such a manner as the Plan Administrator determines to be appropriate;
- To request and receive such information as the Plan Administrator, from time to time, determines to be necessary for the proper administration of this Plan;
- To furnish each Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;
- To receive, review, and keep on file such reports and information concerning the benefits covered by this Plan as the Plan Administrator determines to be necessary and proper;
- To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary and advisable, including legal counsel and benefit consultants;
- To sign documents for the purpose of administering this Plan, or to designate an individual or individuals to sign documents for the purpose of administering this Plan;
- To secure independent medical or other advice and require such evidence as it deems necessary to decide upon any claim or appeal; and
- To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable Disclosure and reporting requirements.

RELIANCE

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and will not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

COMPENSATION OF PLAN ADMINISTRATOR

Unless otherwise determined by the employer and permitted by law, any Plan Administrator who is also an Employee of the employer will serve without Compensation for services rendered in such capacity, but all reasonable expenses Incurred in the performance of their duties will be paid by the employer.

INABILITY TO LOCATE PAYEE

The Plan Administrator will make reasonable efforts to locate Participants. In the event that the Plan Administrator is unable to make benefit Payment to a Participant, the Plan Administrator will hold benefit Payment until the location of the Participant is known or until one year after the end of the Plan Year in which the benefit was payable.

EFFECT OF MISTAKE

In the event of a mistake as to eligibility, allocation of elected contribution amounts, or the Payment of benefits under the Plan, the Plan Administrator reserves the right to correct the mistake, to the extent possible, using any available legal means.

GENERAL PROVISIONS

EXPENSES

All reasonable expenses Incurred in administering the Plan are currently paid by forfeitures to the extent provided by the Plan, and then by the employer.

NO CONTRACT OF EMPLOYMENT

Nothing herein is intended to be or will be construed as constituting a contract or other arrangement between any eligible Employee and the employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the employer.

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan.

The Plan Administrator will provide written notice to You within 60 days following an adopted formal action that makes material changes to the Plan.

AUTHORIZED AGENT TO SIGN AND AUTHORIZE AMENDMENT

Any amendment that is signed and acknowledged by the employer will be deemed to be a valid amendment.

YOUR RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, Your rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not You have received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, Your rights are limited to Covered Expenses Incurred before You receive notice of termination.

The Plan will assume that You receive the written amendment or termination letter from the Plan three days after the Plan mails the letter to You regarding the changes.

No person will become entitled to any vested rights under this Plan.

GOVERNING LAW

This Plan will be construed, administered, and enforced according to the laws of the State of Minnesota, to the extent not superseded by the Code , or preempted by ERISA or any other federal law.

CODE AND ERISA COMPLIANCE

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. (ERISA applies to the Health FSA portion of this Plan only.) This Plan will be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA will be deemed controlling, and any conflicting part, clause, or provision of this Plan will be deemed superseded to the extent of the conflict.

In the event that the Plan fails a nondiscrimination test, the Plan Administrator reserves the right to decrease contribution levels of Highly Compensated or Key Employees.

NO GUARANTEE OF TAX CONSEQUENCES

Neither the Plan Administrator nor the employer makes any commitment or guarantee that any amounts paid to or for Your benefits under this Plan will be excludable from gross income for federal, state, or local income tax purposes. It will be Your obligation to determine whether each Payment under this Plan is excludable from Your gross income for federal, state, and local income tax purposes, and to notify the Plan Administrator if there is any reason to believe that such Payment is not excludable.

INDEMNIFICATION OF EMPLOYER

If You receive one or more Payments or reimbursements that are not for Medical Care Expenses or for Dependent Care Expenses, You must indemnify and reimburse the employer for such amounts, including any liability the employer may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such Payments or reimbursements. Any such amounts may be withheld from an Employee's paycheck to the extent permitted by law. If, at the end of the Plan Year, You have not reimbursed the Plan for the improper Payment, the Plan Sponsor will treat the improper Payment as it would any other business debt.

NON-ASSIGNABILITY OF RIGHTS

Your right to receive any reimbursement under this Plan will not be alienable by assignment or any other method and will not be subject to claims by Your creditors through any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

FORFEITURE OF STALE CHECKS

Any checks that You receive for reimbursement of expenses must be cashed on a timely basis. In particular, the Plan may stop payment on any check that has not been deposited or cashed within one year after the close of the Plan Year in which the check was issued. Any such amounts will be forfeited and used to defray the reasonable expenses associated with administering this Plan.

PLAN HEADINGS

The headings of the various articles and sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

PLAN PROVISIONS CONTROLLING

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of the Plan, the provision of this Plan will be controlling.

SEVERABILITY

Should any part of this SPD be invalidated by a court of competent jurisdiction, the remainder of the SPD will be given effect to the maximum extent possible.

GLOSSARY OF TERMS

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make Payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make Payment that is based on a determination that You are no longer eligible to participate in the Plan.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom a CE Discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Cafeteria Plan means a written plan in which all participants are Employees who may choose between two or more benefits consisting of cash and "qualified benefits" as permitted by Code §125.

Change in Cost means a significant cost increase or a significant cost decrease as determined by the Plan Administrator that applies uniformly to all Covered Persons. A Dependent care provider who is a relative of the Employee may not impose the cost change. A relative is an individual who is related as described in Code §152(d), incorporating the rules of Code §152(f).

Change in Coverage means a prospective election change by a Covered Person that is on account of and corresponds with a Plan benefit change by the employer.

Change in Status means any of the events described in the Change in Status section of this SPD.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives a Covered Person the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Code means the Internal Revenue Code of 1986, as amended.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Compensation means the wages or salary paid to an Employee by the employer, determined prior to any Salary Reduction election under this Plan, prior to any Salary Reduction election under any other Code §125 Cafeteria Plan, and prior to any salary deferral election under any Code §401(k), 403(b), or 408(k) arrangement.

Cosmetic Surgery means any procedure or drug that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat an Illness or disease.

Cosmetics, as defined by the Food, Drug, and Cosmetic Act, means an article intended to be rubbed, poured, sprinkled, or sprayed on, introduced into, or otherwise applied to the human body for cleansing, beautifying, promoting attractiveness, or altering appearance.

Covered Entity (CE) means one of the following: a Health Plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by HIPAA.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving an eligible benefit under this Plan.

Covered Person means You and each of Your Dependents who are enrolled in component benefit plans offered by Your employer under this Plan.

Dependent means any individual who:

- For purposes of the Health FSA, is a Dependent of the Participant as defined in Code §105(b) or Code §125(e), as applicable, and
- For purposes of the Dependent Care Spending Account, is a person defined in Code §21(b)(1) with respect to the Participant. In the case of divorced parents, a child will, as provided in Code §21(e)(5), be treated as a Dependent of the custodial parent and will not be treated as a Dependent of the non-custodial parent. (See the Health Care Spending Account and Dependent Care Spending Account sections for further details regarding Dependent eligibility.)

Dependent Care Expenses means expenses that are considered to be Eligible Employment-Related Expenses under Code §21(b)(2) (related to expenses for household and Dependent Care Services necessary for gainful employment of the Employee and Spouse, if any), if paid for by the Employee to provide qualifying Dependent Care Services.

Dependent Care Services means services related to the care of a Qualifying Individual that enable the Covered Person and Spouse to remain gainfully employed and that are performed inside or outside the Covered Person's home for:

- The care of a Dependent of the Covered Person who is under age 13.
- The care of any other Qualifying Individual that resides at least eight hours per day in the Covered Person's household.

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), then the center must comply with all applicable state and local laws and regulations.

Dependent Care Spending Account means the Dependent Care Spending Account as described in this Plan.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment records, payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure means the release or divulgence of information by an entity to persons or organizations outside that entity.

Earned Income means all income derived from wages, salaries, tips, self-employment, and other Employee Compensation (such as disability or wage continuation benefits), but does not include:

- Any amounts received pursuant to any Dependent care assistance program under Code §129.
- Any amounts received as a pension or annuity.
- Any amounts received pursuant to Workers' Compensation.

Effective Date means the first day of coverage under this Plan as defined in this SPD.

Electronic Protected Health Information (Electronic PHI) means Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Eligible Employment-Related Expenses means those qualifying Dependent Care Services Incurred incident to maintaining employment after the date of the Employee's participation in the Dependent Care Spending Account of this Plan and during the Plan Year, other than amounts paid to:

- An individual with respect to whom a Dependent deduction is allowable under Code §151(c) to the Participant or their Spouse.
- The Participant's Spouse.
- A child of the Participant (within the meaning of Code §152(f)) who is under 19 years of age at the end of the year in which the expenses were Incurred.

For this purpose, a Dependent Care Expense is Incurred only after the services giving rise to the expense have actually been rendered.

Employee - see the Eligibility and Enrollment section of this SPD.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

Full-Time Student or Student means a Student attending high school or an Accredited Institution of Higher Education. In order to be considered a Full-Time Student, a Dependent must receive at least the minimum number of credits determined by the school to be full-time, or the equivalent if the school operates on an alternative-term basis. Alternatively, the Student must meet the accredited college's or university's definition of Full-Time Student. A Student attending a combination of accredited institutions and whose total combined credits meet the requirements listed in this paragraph will also qualify as a Full-Time Student. With respect to a licensed trade school, the Plan requires enrollment in a six-month or longer training program for at least 20 hours per week that awards a formal certification upon graduation, and the school must be accredited by a national governing body.

Health Benefit Plan means the plan(s) that the employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical-type benefits through a group insurance policy or policies (including HMOs). The employer may substitute, add, subtract, or revise, at any time, the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Covered Persons and will automatically be incorporated by reference under this Plan.

Health Care Operations means general administrative and business functions necessary for a Covered Entity to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and Health Plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Health FSA means the Health Care Flexible Spending Account described in this Plan.

Health Plan means any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulation, 65 Fed. Reg No. 250 (82463).

Highly Compensated Employee means an Employee in whose favor discrimination is prohibited under provisions of the Code that apply to Cafeteria Plans and certain other benefit plans. The specific definition differs depending upon the type of plan and the nondiscrimination requirement at issue.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of Protected Health Information, among other things.

Illness means a sickness or disease. Pregnancy and complications of pregnancy are considered Illnesses under this Plan.

Incapable of Self-Care means incapable of caring for one's hygienic or nutritional needs, or requiring full-time attention of another person for one's own safety or the safety of others.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer, who is not an Employee or an officer of the employer, and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with §530 of the Internal Revenue Code.

Individually Identifiable Health Information means information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Key Employee means an Employee who is an officer or shareholder of the employer (as further defined in Code §416) and in whose favor discrimination is prohibited under provisions of the Code that apply to Cafeteria Plans and certain other benefit plans.

Medical Care Expense means an expense Incurred by a Covered Person, for medical care as defined in Code §213(d) (including, for example, amounts for certain hospital bills, doctor bills, and dental bills), other than expenses that are excluded hereunder, but only to the extent that the Covered Person incurring the expense is not reimbursed for the expense (because the expense is not reimbursable) through the Health Benefit Plan, other insurance, or any other accident plan or Health Plan. For a limited-purpose Health FSA, Medical Care Expenses means Code §213(d) eligible dental and vision expenses.

Medically Necessary or Medical Necessity means treatment, services, supplies, Medicines, or facilities necessary and appropriate for the diagnosis, care or treatment of an Illness or Injury that meet all of the following criteria as determined by the Plan:

- The health intervention is for the purpose of treating a medical condition; and
- It is the most appropriate supply or level of service, considering potential benefits and harm to the patient; and
- It is known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- It is cost-effective for a specific condition, compared to alternate interventions, including the option of no intervention. The term "cost-effective" does not necessarily mean for the lowest price; and
- It is not primarily for the convenience or preference of the Covered Person, for the Covered Person's family, or for any provider; and
- It is not Experimental, Investigational, cosmetic, or custodial in nature; and
- It is currently, or at the time the charges were Incurred, recognized as acceptable medical practice by the Plan.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, Treatment plan, supply, Medicine, equipment, or facility, or the fact that such service, Treatment plan, supply, Medicine, equipment, or facility is the only available procedure or Treatment for a condition, does not, in itself, make the utilization of the service, Treatment plan, supply, Medicine, equipment, or facility Medically Necessary.

Medicine or Medication means a substance or preparation that alleviates or treats a sickness, disease, or injury.

Merchant means one whose occupation is the wholesale purchase and retail sale of goods for profit.

Over-the-Counter Drugs/Items means those Medicines or other items that are available to consumers without a Physician's prescription and are used to alleviate or treat a sickness, disease, or injury.

Participant means a person who is an eligible Employee and who is participating in this Plan in accordance with the applicable provisions of this Plan.

Payment means the activities of the Health Plan or a Business Associate, including the actual Payment under the policy or contract, and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Period of Coverage means the Plan Year for Code §213(d) benefits, with the following exceptions: (1) for Employees who first become eligible to participate, it means the portion of the Plan Year following the date participation commences, and (2) for Employees who terminate participation, it means the portion of the Plan Year prior to the date participation terminates.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who performs services payable under this Plan: doctor of medicine (MD); doctor of medical dentistry, including an oral surgeon (DMD); doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); or doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which they practice, the services being provided are within their scope of practice, and the services are payable under this Plan.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's placement with the person terminates upon the termination of such legal obligation.

Plan means the SECUR-SERV Flexible Spending Plan. It consists of a Cafeteria Plan, a Health FSA, and a Dependent Care Spending Account.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Administrator means SECUR-SERV.

Plan Sponsor means any employer who sponsors a group Health Plan.

Plan Year means the consecutive 12-month period of time, designated in the Plan Information section of this SPD, during which the Plan is maintained.

Privacy Official means the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information means Individually Identifiable Health Information that is transmitted by electronic media, maintained in any medium that is considered an electronic medium, or transmitted or maintained in any other form or medium.

QMCSO means a Qualified Medical Child Support Order as defined in Section ERISA 609(a).

Qualifying Individual for purposes of the Dependent Care Spending Account, means:

- A Dependent of the Covered Person who is under the age of 13.
- A Dependent of a Covered Person who is mentally or physically Incapable of Self-Care.
- The Spouse of a Covered Person who is mentally or physically Incapable of Self-Care.

Salary Reduction means the amount by which the Covered Person's Compensation is reduced and applied by the employer under this Plan to pay for one or more of the benefits provided under this Plan.

Spouse means an individual who is legally married to a Participant (and who is treated as a Spouse under the Code). Notwithstanding the above, for purposes of the Dependent Care Spending Account, the term "Spouse" does not include:

- An individual legally separated from the Participant under a divorce or separate maintenance decree.
- An individual who, although married to the Participant, files a separate federal income tax return, maintains a separate principal residence from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of residence of the Participant.

Third Party Administrator (TPA) is a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for Payment of benefits under this Plan.

Transaction means the transmission of information between two parties to carry out financial or administrative activities related to health care.

Treatment means the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the Health Plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

You / Your means the Employee.