Summary Plan Description

of the

GLEN OAKS COMMUNITY COLLEGE
FLEXIBLE BENEFIT PLAN

Revised Effective: January 1, 2015

To Our Employees

This document is called a “Summary Plan Description” (commonly referred to as an “SPD”), and uses a question and answer format to explain how the Flexible Benefit Plan ("Plan") works. The Plan qualifies as a “cafeteria plan” under Section 125 of the Internal Revenue Code, and allows you to tailor your benefits to meet your individual needs from year to year.

You are urged to read this SPD carefully and to keep a copy for future reference. Although every effort has been made to describe the Plan accurately in this document, the provisions of the Plan document serve as the final authority in resolving questions or controversy. You may review a copy of the Plan Document in Human Resources during regular business hours, or you may request a copy in writing for which a reasonable charge may be made.

In the event of any difference between the SPD and the Plan document, the terms of the Plan document will control.

If you have any questions about your benefits under the Plan, please contact Human Resources.

Q-1. What is the Flexible Benefit Plan?

The Flexible Benefit Plan is a plan that allows you to design a benefits package to suit the individual needs of you and your family. You have the following benefit choices under the Plan:

- *Premium Payment Component*—Permits you to pay your portion of the required premium for our Employer-sponsored Benefit Plan(s) on a pre-tax basis.

- *Health Savings Account (HSA)*—Permits you to make pre-tax contributions to an HSA established and maintained outside of the Plan with the Employee's HSA trustee/custodian.

- *Health Flexible Spending Account (FSA)* —Permits you to reduce your pay to be reimbursed on a pre-tax basis for certain qualifying health care expenses incurred by you, your spouse or dependents.

- *Dependent Care Flexible Spending Account (FSA)* —Permits you to reduce your pay to be reimbursed on a pre-tax basis for certain qualifying dependent care expenses that you pay to allow you to work.

More information regarding the types of tax-free benefits that you may choose and the procedures for making your benefit elections are explained in the following sections of this SPD. Although the Plan is intended to comply with the Internal Revenue Code's provisions for flexible benefit plans, the Employer does not guarantee this or any other tax consequences.

References are made throughout this SPD to the "Plan Year." The Plan Year is the 12-month accounting period for the Plan and is set forth in the last section of this SPD.

Q.2. What are the advantages of participating in the Plan?

The advantage to you is that your Plan contributions are made from your pay before taxes are calculated. Therefore, if you are covered under our Employer-sponsored Benefit Plan(s), or will incur an expense that may be reimbursed through an FSA, you can reduce your pay and obtain the coverage or pay the reimbursable expense with "pre-tax" income rather than "after-tax" income. In addition, if you have coverage under the High Deductible Health Plan offered by the Employer, you may contribute to a Health Savings Account (HSA) on a pre-tax basis through the Plan.

Your salary reductions will reduce the amount of your pay that is reported to Social Security, which may affect your Social Security benefits; however, any loss in Social Security benefits can usually be offset easily by directing a portion of your tax savings to a personal or employer-sponsored savings or retirement plan.

Other advantages include:

- *Increased Spendable Income*—By contributing pre-tax dollars, you reduce the amount of your income subject to payroll taxes. So, if you were already paying for eligible expenses with after-tax dollars, you may stretch your buying power further.
- *Convenient Payroll Deduction*—The amount you elect to contribute will automatically be deducted in equal amounts from your paycheck throughout the Plan Year.
- *Budgeting Out-of-Pocket Health Care Expenses*—It's easier for you to budget your out-of-pocket costs since the amount you elect for the year is available to you from the beginning of the Plan Year.

Q.3. What are my benefit choices under the Plan?

For each Plan Year, you may choose from the following benefits:

Employee Contributions to our Employer-Sponsored Benefit Plan(s)

Employer maintains one or more group health plans that provide you and your eligible dependents with various health coverage options. You may be required to pay a portion of the cost of this coverage if you decide to elect coverage. This amount can be automatically deducted from your paycheck on a pre-tax basis.

For purposes of paying the required cost to the Employer-sponsored Health Plans (pre-tax premium payment), eligible dependents are your spouse and any dependents covered under the group insurance plans.

Health Savings Account (HSA) Contributions

If you have elected coverage under the High Deductible Health Plan offered by the Employer, you can contribute to a Health Savings Account (HSA) on a pre-tax basis through the Plan. Benefits provided under the HSA, which consist solely of the ability to contribute to the HSA on a pre-tax salary reduction basis (see Q.26), are called "HSA Benefits".

Health Flexible Spending Account (FSA)

You may use your pay reductions to obtain reimbursement of qualifying health care expenses incurred by you and your family. As described in Q.12, the Health FSA election may be for:

- General-Purpose Health FSA Coverage; or
- Limited-Purpose Health FSA Coverage.

The coverage you may elect will depend on whether or not you have coverage under the High Deductible Health Plan with an HSA.

Dependent Care Flexible Spending Account (FSA)

You may use your pay reductions to obtain reimbursement of qualifying dependent care expenses incurred for the care of a dependent child or adult who is your IRS dependent, to enable you and, if married, your spouse to work.

Q.4 Who is eligible to enroll in the Plan?

Employees who fall into the following classifications and are regularly scheduled to work are eligible to enroll in the Plan: Mid-level administrators, GOSSE union and Faculty Senate union employees. Employees who are student workers, part-time faculty and are any other temporary positions are not eligible to participate in the Plan.

Q.5. When can I participate in the Plan?

For purposes of electing to pay your portion of the cost of your coverage under the Employer-sponsored Benefit Plan(s) on a pre-tax basis, you are eligible to participate in the Plan on the day you become covered in the Employer-sponsored benefit plan(s).

For purposes of participating in the FSAs, you are eligible to participate in the Plan if you are an eligible employee as set forth in Q.4. You have an additional 30-day window to enroll. Your effective date of participation will be the first day of employment, or the first of the month following the date Employer receives your completed enrollment form (if you enroll during the 30-day window), whichever is later. You may only submit claims incurred after your effective date of participation.

Once you become a Participant, your eligible dependents also become covered. For purposes of participating in the Health or Dependent Care FSA, eligible dependents are the following:

(1) your spouse of the opposite sex who was legally married to you under the laws of the state or other jurisdiction where the marriage occurred, where such marriage has not been terminated through divorce or legal separation;

(2) your child, until the end of the year in which your child turns age 26; and

(3) any other individuals who would qualify as a tax dependent under Code Section 105(b).

For purposes of (2) above, your "child" means your son, daughter, stepchild, foster child, or legally adopted child, regardless of such child's tax dependent status, marital status, employment status, student status or residency.

Q.6. How do I enroll in the Plan?

This section describes the procedure for choosing benefits under the Plan. You may generally not change your election during the Plan Year, except as described below.

Initial Benefit Selection

After you satisfy the eligibility requirements described in Q.5, you become a Participant by enrolling in the Plan in the form prescribed by Employer (either in written form or by electronic enrollment). You must enroll within the time period specified in the enrollment materials. If you fail to enroll in the Plan as required will not be able to elect any benefits under the Plan until the next Open Enrollment Period (unless you have one of the mid-year events described in Q.8 that would be consistent to allow you to enroll). Any required premium contributions to the Employer-sponsored group health plans you have elected will automatically be deducted on a pre-tax basis.

Annual Benefit Selection

There will be an Open Enrollment Period before the start of each Plan Year. You may enroll in the Plan in the form prescribed by Employer (either in written form or by electronic enrollment) during the Open Enrollment Period. The new election will become effective as of the first day of the next Plan Year and will remain in effect through the last day of the Plan Year. After you make your annual election, you may change your election only during the next Open Enrollment Period, or if you have one of the events that permit a change during a Plan Year as described in Q.8 below. Any required premium contributions to the Employer-sponsored group health plans you have elected will automatically be deducted on a pre-tax basis.

If you enroll in the Dependent Care FSA, you must complete a Dependent Care Certification Statement at the beginning of each Plan Year. This statement allows us to verify the ages of the qualifying dependents, and that if you are married, your spouse's income exceeds the amount of dependent care expenses claimed.

Q.7. What if I fail to enroll in one or both of the FSAs during the Open Enrollment Period? Can I enroll later?

If you fail to enroll during the Open Enrollment Period to elect one of the FSAs, you will not be able to participate in the Plan for that Plan Year. You will be treated as if you had elected to receive all your compensation in cash, and you will not be allowed to enroll again until the enrollment process begins for the next Plan Year (unless you experience a change in status (see Q.8 below) that would be consistent with allowing you to enroll in one of the FSAs). If you enroll because of a change in status, you must do so within 30 days of the change in status event.

Q.8. Can I make changes to my election during the Plan Year?

With the exception of HSA Benefits (for which prospective election changes generally are allowable), you may only change your benefit election during an Open Enrollment Period; however, you may change your election during a Plan Year in certain situations where federal law permits a new election. The next sections describe these situations.

IRS "Change In Status"

A change in status is an exception to the rule prohibiting any change in your benefit election during a Plan Year. A change in status is limited to situations where your status has changed during the Plan Year and this change affects the benefit election you made earlier.

The following events are changes in status:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment;

- An event that changes the number of your dependents, including birth, adoption, placement for adoption and death of your dependent;

- An event affecting the employment status of you, your spouse or dependent, including a termination or a commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, a change in work site, and any other change in employment status which affects an individual's eligibility for benefits;

- An event that causes your dependent to satisfy or cease to satisfy the requirements of coverage due to the attainment of a specified age, or any similar circumstances; or

- A change in the place of residence of you or your spouse or dependent as long as the move triggers eligibility or causes loss of eligibility under the group health plan, (e.g., employee or dependent moves outside HMO service area).

If you have a change in status, you may change your election under the Plan only if the election change is on account of and corresponds with the change in status that affects eligibility for coverage. Notwithstanding this general rule, if your spouse or dependent loses eligibility for our Employer-provided health coverage and becomes eligible for COBRA under this Plan, you may increase your salary reductions under the Plan in order to pay for the COBRA coverage. (This rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce.) Further, with respect to any group term life insurance, disability or dismemberment coverage benefit election, if the change in status is a change in your legal marital status or a change in the employment status of your spouse or dependent, an election to increase or decrease coverage will be permitted. Finally, with respect to your Dependent Care FSA, an election change may be made if your dependent attains age 13, becomes totally disabled or ceases to be either physically or mentally incapable of self-care, or you change providers, resulting in a different cost (as long as the provider is not a relative).

If you have a change in status during a Plan Year, you may submit a Change in Benefit Election form to the Plan Administrator within 30 days after the change in status occurs. The Change in Election form will be effective at the time prescribed by the Plan Administrator. If you do not submit a Change in Election form within 30 days after the change in status, you must wait until the next Open Enrollment Period to change your election.

FMLA Leave *(Applies to Pre-tax Premium Contributions and Health FSA Benefits)*

You may change an election under the Plan upon FMLA leave, as described in Q.9.

Changes to Coordinate with the Affordable Care Act

Under the Affordable Care Act, you may become eligible for the Employer-provided health coverage for a period of time and not lose eligibility even if you have a change in employment status where your hours of service will be reasonably expected to be reduced to an average of less than 30 hours of service per week. If this occurs, you can elect to cancel the Employer-provided health coverage even if the reduction in hours does not result in you ceasing to be eligible for the coverage. You may revoke coverage in this situation for yourself and any affected family members provided that you enroll in another plan that provides "minimum essential coverage" (as that term is defined under the Affordable Care Act) which is effective no later than the first day of the second month following the month that includes the date your Employer-provided health coverage is revoked.

Similarly, if you are eligible to enroll in a "qualified health plan" (as that term is defined under the Affordable Care Act) through an exchange during a special enrollment period or annual open enrollment period, you can elect to cancel the Employer-provided health coverage. This election is permitted provided that the revocation corresponds to the intended enrollment of you and your family members, if applicable, in a qualified health plan which is effective no later than the day immediately following the date your Employer-provided health coverage is revoked.

Special Enrollment Rights under HIPAA or SCHIP *(Applies to Pre-tax Premium Contributions, but not to Health FSA or Dependent Care FSA Benefits)*

You may have special rights under HIPAA to enroll in Employer-provided group health plan coverage in two situations:

- You have lost other group health coverage. This could occur if your COBRA rights under the other plan were exhausted or you became ineligible for the other plan for a reason other than the nonpayment of premiums.

- You acquire a new dependent by marriage, birth or adoption.

For HIPAA special enrollment rights, you must make your new election within 30 days after the event occurs; however, any retroactive enrollment is limited to birth, adoption, and placement for adoption.

In addition, if an unenrolled but otherwise eligible Employee or such Employee's dependent (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act or under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act due to a loss of eligibility for coverage under Medicaid or CHIP; or (2) becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the Employee is entitled to special enrollment rights under a Benefit Plan Option that is a group health plan and an election change to correspond with the special enrollment right is permitted. However, you must request enrollment **within 60 days** after your Medicaid or CHIP coverage is terminated due to a loss of eligibility or you become eligible for premium assistance subsidy, as applicable. Thus, for example, if an otherwise eligible Employee has medical coverage under Medicaid or SCHIP and eligibility for such coverage is subsequently lost, the Employee may be able to elect medical coverage under a Benefit Option for the Employee and his or her eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible employee and/or dependent gains eligibility for group health plan premium assistance from SCHIP or Medicaid, the employee may also be able to enroll the Employee, and the Employee's Dependent, provided that a request for enrollment is made within the 60 days from the date of the loss of other coverage or eligibility for premium assistance. Please refer to the group health plan summary description for an explanation of special enrollment rights.

Certain Judgments, Decrees and Orders *(Applies to Pre-tax Premium Contributions and Health FSA Benefits, but not to Dependent Care FSA Benefits)*

You may change your election because of a court order resulting from a divorce, legal separation or change in legal custody that requires health coverage for one or more of your children. Specifically, you may:

- Elect coverage for the child if the court order requires you to add the child to the Employer-provided health coverage in which you are enrolled; or

- Cancel coverage for the child if the court order requires the spouse, former spouse or other person to provide coverage. However, coverage can only be cancelled if the child actually becomes covered under the plan of the spouse, former spouse or other person to provide coverage.

Medicare, Medicaid or CHIP Coverage *(Applies to Pre-tax Premium Contributions, to Health FSA Benefits as Limited Below, but not to Dependent Care FSA Benefits)*

If you, your spouse, or a dependent becomes entitled to Medicare, Medicaid or coverage under a state children's health insurance program (CHIP) under Title XXI of the Social Security Act, you may elect to cancel or reduce your group health plan coverage and/or the Health FSA coverage. Similarly, if you, your spouse, or a dependent who has been entitled to Medicare, Medicaid or CHIP coverage loses eligibility for such coverage, you may begin group health plan coverage for that individual or increase Health FSA coverage. You must request an election change to enroll in group health plan coverage within 60 days from the date (1) the coverage terminates under the Medicare, Medicaid or CHIP plan; or (2) the employee, spouse or dependent child is determined eligible for state premium assistance. A request for a Special Enrollment right must be made within 60 days of an event described above.

Cost and Coverage Changes *(Applies to Pre-tax Premium Contributions and Dependent Care FSA Benefits, but not to Health FSA Benefits)*

If the cost of coverage under Employer's group health plan or one of Employer's other benefit plans in which you participate changes during the Plan Year, your salary reductions will automatically be increased or decreased to reflect the adjustment in cost; however, if the cost increase is significant, you may either agree to the increase or change your election to another comparable benefit option, if one exists. If there is no other benefit option available that provides similar coverage, you may drop coverage prospectively.

With respect to your Dependent Care FSA, if the cost of care increases or decreases during the Plan Year, you may adjust your election. However, this opportunity is not available if the dependent care provider is your relative. Also, you may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider, or when the dependent enters or leaves school. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, you may change coverage to reflect the cost of the new service provider; (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, you may cancel coverage; and (c) if enrollment in school decreases the necessary hours of dependent care, you may reduce your election.

If coverage under the Employer-provided group health plan or one of Employer's other benefit plans in which you participate is significantly curtailed or ceases during the Plan Year, you may elect to receive coverage under another comparable benefit option. Further, if Employer offers a new benefit or coverage option, you may prospectively elect the new option. Conversely, if the Employer eliminates an option, you may prospectively elect another option that provides similar coverage, if one exists; however, if you make a change to cease or decrease coverage, the Employer may require certification from you that you are covered, or proof of coverage from the other employer's plan.

If you or your spouse or dependent loses coverage under any other welfare benefit plan sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs), you may add coverage for yourself, your spouse or dependent.

Finally, if you, your spouse or dependent has a change in coverage under the plan of the employer of your spouse or dependent where the change is as a result of one of the circumstances described in this section or where the change is made during the annual Open Enrollment Period of the other employer's plan, you may make a corresponding election change under this Plan.

Change in HSA Elections *(Applies to HSA Benefits)*

If you have enrolled in the Plan and have elected HSA Benefits, then you may increase, decrease or revoke your HSA Benefits election on a prospective basis as often as monthly during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. No other benefits package option election changes can be made as a result of a change in your HSA Benefits election unless permitted as a result of events otherwise described in this Q-7. For example, generally you would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described above for Health FSA election changes otherwise applied (such as a change in status).

Nondiscrimination Rules *(Applies to Pre-tax Premium Contributions, Health FSA and Dependent Care FSA Benefits)*

The Employer/Plan Administrator may modify your contributions during the Plan Year if you are a key employee or highly compensated employee (as defined by the Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q.9 How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence. If Employer is subject to FMLA (Family and Medical Leave Act of 1993; generally, employers with at least 50 employees within a 75-mile radius are subject to the FMLA) and you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, your Employer will continue to maintain your health coverage (including Health FSA coverage) on the same terms and conditions as though you were still active (i.e., the Employer will continue to pay its share of the premium to the extent you opt to continue coverage). Your Employer may elect to continue all health coverage (including Health FSA coverage) for Participants while they are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the premiums by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis if that is what was used before the FMLA leave began).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), and you opt to continue your health coverage (including Health FSA coverage), then you may pay your share of the premium in one of three ways:

(1) with pre-tax dollars to the extent you receive compensation during the leave, or by pre-paying all or a portion of your share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation would normally be available to you, but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year);

(2) with after-tax dollars while on leave; or

(3) by other arrangements agreed upon between you and your Employer (for example, your Employer may pay for coverage during the leave and withhold "catch up" amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue health coverage and Health FSA coverage during the unpaid leave, you may discontinue paying your share of the required premium until you return from leave. Upon returning from leave, you must pay your share of any required premiums that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, as you and the Plan Administrator may agree.

If your health coverage or Health FSA coverage ceases while on FMLA leave, (e.g., for non-payment of required contributions), you will be entitled to re-enter such benefits, as applicable, upon return from such leave on the same basis as you were participating in the Plan before the leave, or otherwise required by the FMLA. You are entitled to have coverage for such benefits automatically reinstated so long as coverage for employees on non-FMLA leave is automatically reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA benefits, if your coverage ceased you will be entitled to elect whether to be reinstated in the Health FSA benefits at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not pay premiums. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA coverage will equal the amount withheld before the FMLA leave.

If you terminate coverage in your Health FSA during the FMLA leave, your account cannot be used to reimburse expenses incurred during the FMLA leave. If you elect to reinstate your Health FSA coverage upon your return, you may not retroactively elect Health FSA coverage for claims incurred during the leave period.
Upon your return, you have the choice between:

- resuming coverage at a reduced coverage level (e.g., assume that you elected $1,200 annual Health FSA coverage with $100 monthly premiums; at the end of month 3 in the 12-month coverage period, you go on a 3-month unpaid FMLA leave and revoke coverage; upon return, you resume the $100/month premium, so you have $900 annual Health FSA coverage for the remainder of the coverage period reduced by prior reimbursements (claims incurred during the leave period when coverage was terminated cannot be reimbursed), or;

- resuming coverage at the level in effect before the FMLA leave with make-up contributions (e.g., assume that you elected $1,200 annual Health FSA coverage with $100 monthly premiums; at the end of month 3 in the 12-month coverage period, you go on a three-month unpaid FMLA leave and revoke coverage; upon return, you elect to resume coverage at the preexisting $1,200 level, so make-up contributions of $300 are required; therefore, upon return, the premium is $150/month, and you have $1,200 annual coverage for the remainder of the coverage period reduced by prior reimbursements (claims incurred during the leave period when coverage was terminated cannot be reimbursed).

For purposes of the Dependent Care FSA, expenses you incur while on a leave of absence are not eligible for reimbursement since they are not expenses you pay so that you can work. When you return from an unpaid leave of absence, the Employer will continue your previous payroll deduction amounts unless you instruct the Employer to accelerate your deductions so that your original annual election will be met (to obtain reimbursement for your dependent care expenses incurred prior to and after your leave of absence).

Non-FMLA Leaves of Absence. If you go on an unpaid non-FMLA leave of absence that does not affect eligibility, then you will continue to participate and the premium due for you will be paid by pre-payment before going on leave, after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by your Employer. If you go on an unpaid leave that affects eligibility, you may continue your health coverage (including Health FSA coverage) under COBRA (see Q. 23).

Q.10 Can you tell me more about the FSAs?

There are certain health care expenses that you or your family may incur that are not covered under our Employer-sponsored Benefit Plan(s) or your spouse's employer's group health plan if you have coverage under your spouse's plan. Also, if you have children or other dependents, you may have to pay others to provide care for them while you are at work. You may be reimbursed for these health care and dependent care expenses under the Flexible Spending Accounts (FSAs). The FSAs allow you to pay certain qualifying expenses using "pre-tax" income rather than "after-tax" income. Your salary reductions are converted into the tax-free reimbursement of certain qualifying expenses.

The FSAs operate as follows. The Employer and/or Benefit Administrator will keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the FSAs are paid as needed from the Employer's general assets. You may not use amounts allocated to one account to receive reimbursement for another type of benefit.

Q.11 How do I decide how much to set aside for the Health FSA?

It is entirely up to you to determine whether to allocate any pay reductions to a Health FSA and, if so, how much to reduce your pay. However, the maximum amount you may have credited to your Health FSA for a Plan Year is $2,550. This amount may be automatically increased annually as indexed due to cost of living adjustments.

If you know you will have qualifying health care expenses during the Plan Year that will not be covered by your health insurance plan or by any other source, you should consider putting enough in your Health FSA to cover these planned-for expenses. The amount in your account will be used to pay all the qualifying health care expenses for which you are responsible; however, you will still be required to pay for any expenses that exceed the amount in your account.

In deciding on the amount to put in your account, it's wise to be conservative and use the account for *predictable* expenses. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next Plan Year. At the end of the Plan Year, all unused amounts must be forfeited.

Q.12 What types of expenses are eligible for reimbursement from the Health FSA?

Your Health FSA election may be for:

- General-Purpose Health FSA option; or
- Limited-Purpose (Dental or Vision) Health FSA option.

Each of these Health FSA coverage options is described in detail below. Note: If you or your spouse have coverage under a qualifying high deductible health plan with a Health Savings Account (HSA), you cannot participate in a General-Purpose Health FSA. Doing so would make you or your spouse an ineligible individual for a Health Savings Account.

The types of expenses eligible for reimbursement vary according to the type of option that is elected. Qualifying health care expenses may be incurred by you, your spouse or your eligible dependents.

General-Purpose Health FSA Option (for individuals NOT covered under a qualifying High Deductible Health Plan with a Health Savings Account). Under the General-Purpose Health FSA Option, a qualifying health care expense is an expense that has been incurred by you and/or your eligible dependents (see Q.5) that satisfies the following conditions:

- the expense is for "medical care" as defined by Code Section 213(d); and

- the expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. Over-the-counter drugs and medicines will not constitute a qualifying health care expense unless prescribed by a physician. Over-the-counter products and devices other than drugs or medicine will still constitute a qualifying health care expense even if not prescribed by a physician (for example, contact lens solution or bandages are eligible for reimbursement without a prescription). For a resource to determine if the OTC item requires a written doctor's prescription, go to www.arcadiabenefits.com and click on the link to the FSA Store.

Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. "Stockpiling" of over-the-counter drugs (even with a prescription) and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator).

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

- Health insurance premiums; and

- Expenses incurred for qualified long-term care services.

Limited-Purpose (Dental and Vision) Health FSA Option (for individuals who are covered under the High Deductible Health Plan with HSA Benefits). According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), you will not be able to make contributions to your HSA if you participate in the General-Purpose Health FSA Option. You may, however, be eligible to make and receive tax-favored contributions to and distributions from an HSA and participate in a Limited-Purpose Health FSA, if the Health FSA reimbursement is limited to the following unreimbursed Code Section 213(d) expenses:

- Services or treatments for dental care (excluding premiums); or
- Services or treatments for vision care (excluding premiums).

Q.13 How do I make a claim for reimbursement under the Health FSA?

You should send your claims for reimbursement of qualifying health care expenses to the Benefit

Administrator, Arcadia Benefits Group. You will need to provide the information required on the Request for Reimbursement form furnished by Arcadia Benefits Group and proper documentation of your expense. Proper documentation includes legible itemized receipts or statements which include the date of service for the charge, the description and amount of the charge, the name of the person for whom the expense was incurred and the name and address of the person or entity to which the expense was paid. Credit card slips, check copies, or "balance due" statements cannot be accepted as the itemization required to process the claim. If the expense is covered by a group health plan, the Benefit Administrator may request a copy of the Explanation of Benefits (EOB) to verify the amount of your out-of-pocket portion.

You may also submit claims securely via Arcadia's online access by scanning your documentation. If submitting online, no claim forms are required.

The Benefit Administrator may request a letter of medical necessity from your physician for certain charges (e.g., massage therapy, exercise equipment, etc.) under the General-Purpose Health FSA Option. The letter must reference the specific medical condition, the specific treatment recommended and the length of time that treatment is recommended.

For orthodontia expense reimbursement, the Benefit Administrator may require that you submit a copy of your Truth in Lending Statement (contract/treatment plan) with your initial claim submission, itemizing the estimated treatment period, down payment and amount of monthly payments, and the amount covered by insurance, if any. You may submit a copy of your monthly payment coupon and/or itemized receipts each time you request reimbursement for ongoing treatment. The Plan cannot reimburse for future service or for the portion of treatment occurring in a subsequent Plan Year unless you choose to prepay orthodontia expenses in a lump sum at the beginning of treatment.

The Health FSA resembles an insurance policy. You are entitled to uniform coverage throughout the Plan Year. For example, if you incur $100 of qualifying health care expenses during the first month of the Plan Year, you may be reimbursed for those expenses immediately, even if you only have $50 credited to your account during that month; however, claims may not be reimbursed to the extent that they exceed the total amount of pay reductions you have allocated to your Health FSA for the Plan Year. Also, only claims for qualifying expenses will be reimbursed.

Your Dependent Care FSA reimbursement will be limited to the amount that you have had deducted from your paycheck as of the date your claim is submitted. (The annual level of coverage is not available to you from the beginning of the Plan Year as it is for the Health FSA.)

You are responsible for making sure that duplicate claims are not submitted to the Benefit Administrator. The Benefit Administrator's claim system will flag any duplicate claims based on date of service, patient name and amount, and such duplicate claims will be denied as previously considered.

In addition, if a participant is found to have committed fraudulent activities at any time during employment with the Employer, that participant will no longer be permitted to participate in the Plan. Any claims previously paid that are found to be fraudulent will be required to be repaid to the Plan. Such fraudulent activity may also result in termination of employment.

Claims are generally processed within two business days of receipt by the Benefit Administrator. Reimbursement checks are issued daily.

Q.14 How do I decide how much to set aside for the Dependent Care FSA?

It is entirely up to you to determine whether to allocate any pay reductions to your Dependent Care FSA and, if so, how much to reduce your pay. If you know you will have dependent care expenses during the Plan Year, you should consider putting enough in your Dependent Care FSA to cover these planned-for expenses. The amount in your account will be used to pay all the dependent care expenses for which you are responsible; however, you will still be required to pay for any expenses that exceed the amount in your account.

In deciding on the proper amount to put in your account, it is wise not to put in too much. For example, if you do not have to pay for dependent care on holidays and while you are on vacation or if your child is ill, you should take this into consideration when you determine the amount you wish to have credited to your account. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next Plan Year. At the end of the Plan Year, all unused amounts must be forfeited.

Q.15 What is the difference between the Dependent Care FSA and the Dependent Care Tax Credit?

The Internal Revenue Code gives you two choices in the treatment of dependent care expenses for income tax purposes. First, you may pay for dependent care expenses with "pre-tax" income through the Plan.

Second, you may claim a Dependent Care Tax Credit on dependent care expenses (a percentage based on your combined adjusted gross income). For most individuals, participating in a Dependent Care FSA will produce the greater federal tax savings, but there are some for whom the opposite is true. (And in some cases, the federal tax savings from participating in a Dependent Care FSA will be only marginally better.) Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of qualifying dependents, earned income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 ("Child and Dependent Care Expenses") to help you and you may wish to consult a tax advisor.

Regardless of which method you choose, please be aware that you must state on your federal income tax return the name, address and social security number of the person (or Tax I.D. number if a corporation) who is providing the dependent care to your dependents by completing Form 2441.

Q.16 What is the Dependent Care Tax Credit?

The Dependent Care Tax Credit is an allowance for a percentage of your annual dependent care expenses as a credit against your federal income tax liability under the U.S. Tax Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual dependent care expenses. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one qualifying dependent, or $6,000 for two or more qualifying dependents. Depending on your combined adjusted gross income (income of you and your spouse, if married), the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one qualifying dependent or $2,100 for two or more qualifying dependents) to a minimum of 20% of such expenses (producing a maximum credit of $600 for one qualifying dependent or $1,200 for two or more qualifying dependents). The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

> **Illustration:** Assume that you are married and have one qualifying Dependent for whom you have incurred dependent care expenses of $3,600, and that your combined adjusted gross income is $20,000. Since only one qualifying dependent is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of expenses. The percentage is 32% (it comes from a table on IRS Form 2441). Thus, your tax credit would $3,000 x 32% = $960. If you had incurred the same expenses for two or more qualifying dependents, your credit would have been $3,600 x 32% = $1,152, because the entire ex-

pense would have been taken into account, not just the first $3,000.

For more information about how the Dependent Care Tax Credit works, see IRS Publication 503 ("Child and Dependent Care Expenses"). You may also wish to consult a tax advisor on which option is better for you.

Q.17 If I participate in the Dependent Care FSA, will I still be able to claim the Dependent Care Tax Credit on my Federal Income Tax Return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the balance of your qualified dependent care expenses may be eligible for the Dependent Care Tax Credit. Effective for tax years beginning after December 31, 2002, the $3,000 and $6,000 are reduced dollar-for-dollar by the amounts contributed to the Dependent Care FSA.

For example, Employee A has one child in day care and has $2,000 in expenses. This employee contributes $1,500 to the Dependent Care FSA. Therefore, Employee A can take a tax credit on the remaining $500 of expenses.

Employee B has two children in day care and is participating at the maximum level allowed under the plan, or $5,000 per calendar year. Employee B's actual dependent care expenses are $6,000. Therefore, Employee B can take a tax credit on the additional $1,000 of expenses starting in 2003.

Q.18 What types of expenses are eligible for reimbursement from the Dependent Care FSA?

Dependent Care Expenses means employment-related expenses incurred on behalf of a person who meets the requirements to be a Qualifying Individual, as defined below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

- Each person for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:
    - a person under age 13 who is your qualifying child under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
    - your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
    - a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition).

If you are married, your spouse must also be working or be a full-time student. For purposes of the Plan, a child of divorced parents who is under age 13 or is either physically or mentally incapable of self-care will be treated as a dependent of the custodial parent, even if the child is a dependent of the non-custodial parent for income tax purposes.

You **cannot** obtain reimbursement for the following expenses:

- Amounts paid for food, clothing, education and entertainment. However, you can include small amounts paid for these items if they are incident to (and cannot be separated from) the cost of caring for the qualifying dependent.
- Educational expenses for grades kindergarten and beyond. However, if a portion of private kindergarten tuition is for childcare, that portion may be reimbursed. (The school must provide a statement showing a break down of educational vs. childcare expenses.)

- Overnight camp expenses (however, day camp expenses are eligible as long as they are employment related).

- Transportation expenses (unless the transportation is furnished by the dependent care provider), including the costs of bus, subway, taxi or private car. Also, if you pay the transportation cost for the care provider to come to your home, you cannot submit this expense cost as a work-related expense.

Q.19 May amounts paid to my relatives be reimbursed?

You may hire whomever you wish to provide services to your dependents. However, federal law provides that dependent care expenses cannot be reimbursed under the Plan if one of the following relatives provides the care:

- One of your dependents;

- Your spouse; or

- Your child (even if not your dependent), if the child is under age 19 on December 31 of the year during which the care is provided.

Q.20 Are there limits on how much may be reimbursed?

Federal law limits the amount of dependent care expenses that may be reimbursed under the Plan. Generally, the limit is $5,000 per calendar year (or $2,500 if you are married and file a separate tax return).

The amount of dependent care expenses claimed cannot exceed the lower of your earned income, or your spouse's earned income. Further, if your spouse is a full-time student or is either physically or mentally incapable of self-care for any month in which you have dependent care expenses, your spouse will be considered to have the following pay for that month:

- $250, if you have dependent care expenses for one dependent; or
- $500, if you have dependent care expenses for more than one dependent.

Q.21 How do I submit a claim for reimbursement for dependent care expenses?

You should send your claims for reimbursement of dependent care expenses to the Benefit Administrator (see the last section of this SPD). You will need to provide the information required on a Request for Reimbursement form furnished by Employer or the Benefit Administrator, and include a receipt or itemized statement for documentation of your expense. This documentation includes the "from/through" date of service, a description of the charge (i.e., childcare or pre-school), the amount of the charge, the dependent's name and the name of your dependent care provider. Sample receipts may be obtained from the Benefit Administrator.

You may also submit claims securely via Arcadia's online access by scanning your documentation. If submitting online, no claim forms are required.

Your claim cannot be submitted until after the services have actually been rendered. For example, if you

pay your childcare weekly on Monday for that week, you should submit your claim on Friday after the services have been rendered. If you pay your childcare expenses on a monthly basis, you will need to wait until the last day of the month to submit for reimbursement.

A claim will only be paid to the extent of the balance in your account at the time the claim is filed. If the balance in your account is insufficient to pay the claim in full, the unpaid balance of the claim will be carried over and paid when a sufficient amount is credited to your account later in the Plan Year. Also, only claims for qualifying expenses will be reimbursed.

In addition, if a participant is found to have committed fraudulent activities at any time during employment with the Employer, that participant will no longer be permitted to participate in the Plan. Any claims previously paid that are found to be fraudulent will be required to be repaid to the Plan. Such fraudulent activity may also result in termination of employment.

Claims are generally processed within two business days of receipt by the Benefit Administrator. Reimbursement checks are issued daily. A web site is available to access information on your FSA account balance and claims history (refer to information on the Benefit Administrator under the "General Information About the Plan" section of this SPD).

Q.22 When are expenses incurred?

To be reimbursed, health care or dependent care expenses must have been incurred during the Plan Year. An expense is *incurred* when the service that gives rise to the expense is actually provided; when the expense is billed or paid is irrelevant.

Q.23 What happens if I terminate employment during the Plan Year?

If you terminate employment you will be ineligible to have any additional pay reductions under the Plan credited to your Health FSA or Dependent Care FSA. If you have amounts remaining in your accounts, you may continue to turn in claims for reimbursement of health care expenses incurred before you terminated employment. Health care expenses incurred before your date of termination, and before the end of the Plan Year may be submitted within 90 days following the end of the Plan Year. With respect to your Health FSA, you will not be eligible to be reimbursed for claims for reimbursement of expenses incurred after you terminated employment, except as explained in the next paragraph. Dependent care expenses incurred after your date of termination, but before the end of the Plan Year may be submitted within 90 days following the end of the Plan Year, as long as the expenses are employment related (in other words, an expense you pay so you can work or look for work).

If you are rehired after 30 days during the same Plan Year of your termination of employment or layoff, there are special rules that may restrict your participation in the Plan until the following Plan Year. If you terminate and are rehired, you should contact Employer for further details regarding these special eligibility requirements.

COBRA Continuation Coverage. "Continuation Coverage" means your right, or your Spouse's and Dependents' rights, to continue the same coverage under any component medical benefit plan (including your Health FSA coverage, but not your Dependent Care 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 such Qualifying Event. Continuation coverage under federal law is provided under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Where Employer is subject to COBRA, if the amount of benefits remaining exceed the amount of COBRA coverage (in general if you have a positive Health FSA account balance at the time of a Qualifying Event taking into account all claims submitted before the date of the qualifying event), you will generally be eligible to continue to participate for the remaining portion of the Plan Year during which your participation terminated.
A Qualifying Event is:

- termination of your employment – voluntary or involuntary (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 (only if plan coverage is lost); or
- your dependent child ceasing to meet the plan's definition of dependent child

For a Qualifying Event other than a change in your employment status, death or entitlement to Medicare, it will be your obligation to inform the Plan Administrator of the qualifying event within 60 days of its occurrence. You must notify the Plan Administrator in writing with the name and address of the person who experienced the event, which event occurred and the date it occurred. The Plan Administrator, in turn, will furnish you (and your Spouse, as the case may be) with written options to continue the coverage provided at stated premium costs with respect to each health plan in which you are participating. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage. You may pay premiums for COBRA coverage under our medical/dental plan on a pre-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis). For example, if you become ineligible for coverage under our medical/dental plan because you change from full-time to part-time status, you may pay premiums for COBRA coverage on a pre-tax basis through the Pre-tax Premium portion of the Plan.

COBRA is generally not available for a subsequent Plan Year unless, pursuant to federal regulations, certain requirements are met (e.g., your Health FSA is not considered an excepted benefit under HIPAA).

If you are eligible to elect COBRA with respect to your Health FSA, you may continue participation by making after-tax contributions to the Plan on a monthly basis in an amount equal to 102% of the salary reductions that were allocated to your Health FSA each month before you terminated participation. After-tax contributions for a month are due on the first day of that month. However, there is a 30-day grace period for timely payment. Participation will be terminated if contributions are not made on a timely basis.

If you participate in the Health FSA and you go on a military leave of absence, Employer will comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) with respect to the Plan. However, these requirements will only apply to the extent they provide you with more favorable coverage than under COBRA, (i.e., coverage for a longer period of time or less costly coverage).

Q.24 When would I risk forfeiting my FSA balance?

Your pay reductions for each Plan Year may only be used to reimburse qualifying expenses incurred during that Plan Year. You are not allowed to transfer unused amounts from one FSA to another FSA (e.g., Health FSA to Dependent Care FSA). Federal law requires that amounts left after reimbursing expenses incurred during the Plan Year must be forfeited. However, Participants will be allowed to carry over up to $500 of unused Health FSA amounts for qualified medical expenses incurred during the following year. This limited $500 carryover applies to the Health FSA benefit (and does not apply to the Dependent Care FSA benefit). Any amounts over $500 remaining in the Health FSA benefit will be forfeited.

Remember, for purposes of the Plan, an expense is "incurred" when the service is rendered or the supply is provided, not when you pay for the expense or are billed for the expense.

Claims for expenses incurred during a Plan Year may only be reimbursed out of your account for that Plan Year. All claims incurred during a Plan Year must be submitted no later than 90 days after the end of the Plan Year. If you do not submit a claim by the required date, the claim will be denied.

Q.25 What happens if my claim for benefits is denied?

Group Health Plan Coverage Claims. If your claim is for a benefit under an Insurance Plan, you will generally proceed under the claims procedure applicable under that plan or policy, as described in the policy, Plan Document or Summary Plan Description for the applicable Insurance Plan.

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

Claims Under the Plan. However, if (a) a claim for reimbursement under the Health FSA or Dependent Care FSA components of the Plan is wholly or partially denied, or (b) you are denied a benefit under the Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to your coverage under the Plan (for example, a determination of: a Change in Status; a "significant" change in premiums charged; or eligibility and participation matters under the Plan), then the claims procedure described below in this Q.25 will apply.

Step 1: *Notice is received from Benefit Administrator*. If your claim is denied, you will receive written notice from the Benefit Administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Benefit Administrator, the Benefit Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Benefit Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Benefit Administrator, review it carefully. The notice will contain:

a. the reason(s) for the denial and the Plan provisions on which the denial is based;
b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
d. a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Benefit Administrator and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from Benefit Administrator.* If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Benefit Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Benefit Administrator.

Step 6: *If you still disagree with the Benefit Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Benefit Administrator's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the

first level appeal denial notice from the Benefit Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Other important information regarding your appeals:

- (Health FSA Only) Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Q.26 What are "HSA Benefits"?

An HSA permits employees to make pre-tax contributions to an HSA established and maintained outside the Plan with your trustee/custodian. For purposes of this Plan, HSA Benefits consist solely of the ability to make such pre-tax contributions under the Plan.

To participate in the HSA Benefits, you must be an "HSA-Eligible Individual." This means that you are eligible to contribute to an HSA under the requirements of Internal Revenue Code Section 223 and that you have elected qualifying High Deductible Health Plan coverage offered by the Employer and have not elected any disqualifying non-High Deductible Health Plan coverage. If you elect HSA Benefits, you will be required to certify that you meet all of the requirements under Code Section 223 to be eligible to contribute to an HSA. These requirements include such things as not having any disqualifying coverage—and you should be aware that your Spouse's coverage could make you ineligible to contribute to an HSA. To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see the most recent version of IRS Publication 969 ("Health Savings Accounts and Other Tax-Favored Health Plans"). In order to elect HSA Benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian.

HSA Benefits cannot be elected with the General-Purpose Health FSA Option. HSA Benefits can only be elected with the Limited-Purpose (Vision, Dental/Preventive Care) Option.

In the event that an expense is eligible for reimbursement under both the Limited-Purpose Health FSA and the HSA, you make seek reimbursement from either the Health FSA or the HSA, but not both.

Q.27 What is my "HSA"?

The HSA is not an employer-sponsored employee benefit plan—it is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code Section 223. Consequently, an HSA trustee/custodian, not the Employer, will establish and maintain your HSA. Your HSA is administered by your HSA trustee/custodian. The Employer's role is limited to allowing you to contribute to your HSA on a pre-tax basis under this Plan. Your Employer has no authority or control over the funds deposited in your HSA. As such, the HSA identified above is not subject to the Employee Retirement Income Security Act of 1974 (ERISA)

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

Q.28. What are the maximum HSA Benefits that I may elect under the Plan?

The amount you elect must not exceed the statutory maximum amount allowable under Code 223 of the Internal Revenue Code. In addition, the maximum annual contribution shall be reduced by any matching (or other) Employer contribution made on your behalf by Employer.

Q.29 Can I change my HSA contribution under the Plan?

As described in Q8, you may increase, decrease or stop your HSA contribution election at any time during the Plan Year for any reason by submitting an election change form to the Employer. Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change. Your ability to make pre-tax contributions under this Plan to the HSA identified above ends on the date that you cease to meet the eligibility requirements.

Q.30 Where can I get more information on my HSA and its related tax consequences?

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

Important Information About Your Plan

The Employer maintains the Plan for the exclusive benefit of and to provide certain non-taxable benefits to its eligible employees and their legal and eligible dependents. With the exception of HSA Benefits and Dependent Care FSA benefits, the Plan is intended to comply with the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

The following information, together with the information contained in the Plan document and Summary Plan Description, is intended to comply with the Plan Administrator's ERISA disclosure obligations. The Plan document may be obtained from the Plan Administrator by written request at the address below.

General Information About the Plan

Plan Name:	Glen Oaks Community College Flexible Benefit Plan
Type of Plan:	Flexible Benefit Plan under Internal Revenue Code Section 125
Plan Year:	January – December
Plan Number:	511
Type of Plan Administration:	This Plan is administered by Glen Oaks Community College, and through an administrative agreement with the Benefit Administrator. Claims for benefits are sent to the Benefit Administrator at: Arcadia Benefits Group, Inc. 612 S. Park St. Kalamazoo, MI 49007 (269) 744-3431 or (866) 329-4333 voice

	(269) 381-5844 facsimile www.arcadiabenefits.com
Name, Address & Phone Number of Plan Sponsor:	Glen Oaks Community College 62249 Shimmel Centreville, MI 49032 (269) 294-4229
Plan Sponsor's Employer Identification Number:	38-1800033
Effective Date of this SPD:	January 1, 2015
Plan Administrator and Named Fiduciary:	Glen Oaks Community College
Agent for Service of Legal Process:	Glen Oaks Community College Attn: Human Resources 62249 Shimmel Centreville, MI 49032

Qualified Medical Child Support Order

The components of this Plan that are group health plans extend benefits to a Participant's non-custodial child, as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Administrator.

Newborns' and Mothers' Health Protection Act of 1996

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

Use and Disclosure of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the Employer's health privacy policies.

How the Plan is Administered

The administration of the Plan is under the supervision of the Plan Administrator, Glen Oaks Community College, and Glen Oaks Community College is the Named Fiduciary for the Plan. The principal duty of the Plan Administrator is to see that the Plan is
carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

Glen Oaks Community College will indemnify each Glen Oaks Community College employee to whom it or the Plan Administrator has delegated responsibilities for the operation and administration of the Plan against any and all claims, loss, damages, expense and liability arising from any action or failure to act,

except when it is judicially determined to be due to the gross negligence or willful misconduct of the employee.

The benefits provided under the Plan will be paid, to the extent permitted by ERISA and the Internal Revenue Code, from the general assets of the Employer and employee contributions. Nothing in this Plan will be construed to require the Employer to maintain any fund for its own contributions or segregate any amount which it is obligated to contribute for the benefit of any participant, and no participant or other person will have any claim against, right to, or security or other interest in, any fund account or asset of the Employer from which any payment under the Plan may be made.

The Plan Administrator has full discretionary authority to: interpret the Plan; determine eligibility for and the amount of benefits; determine the status and rights of participants, beneficiaries and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the authority contemplated by ERISA and the Code with respect to the Plan; employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the Plan. The Plan Administrator has the requisite discretionary authority and control over the Plan to require deferential judicial review of its decisions.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan fiduciaries and may delegate fiduciary or other responsibilities to others. Any such allocation or delegation must be done in writing and kept with the records of the Plan. The Plan Administrator is only delegating its discretionary authority to determine eligibility, rights to benefits and to construe the plan with respect to the specific benefit the insurer is providing, but that it retains full discretionary authority with respect to the rest of the Plan.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another Plan fiduciary to the extent provided in ERISA §405(a).

If you have any general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of any benefits payable under the Plan, please contact the Benefits Administrator.

Amendment or Termination of the Plan

Glen Oaks Community College, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by Glen Oaks Community College, which is authorized by its governing body to amend or terminate the Plan. Upon termination of the Plan, only benefits to which you became entitled, or expenses that were incurred prior to termination will be covered under the Plan.

Limitation on Rights

The Plan does not constitute a contract between you and Glen Oaks Community College, nor is it to be consideration or inducement for your employment. Nothing contained in the Plan gives you the right to be retained in the service of Glen Oaks Community College or to interfere with the right of Glen Oaks Community College to discharge you at any time, with or without cause (subject only to the provisions of any relevant collective bargaining agreement), regardless of the effect which that discharge will have upon you as a participant in the Plan.

Claims Procedures

The Plan Administrator is responsible for evaluating all initial benefit claims under the Plan. The Plan Administrator will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The Plan Administrator has the right to require such other evidence as it deems necessary in order to decide your claim.

If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

See Q.13 for more information about how to file a health care claim and Q.25 for details regarding claims appeals and the Plan Administrator's claims procedures.

Statement of ERISA Rights

As a participant in the Glen Oaks Community College Flexible Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office, all documents governing the plan, including insurance contracts and the Plan document, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of the Plan documents governing the operation of the plan, and copies of the latest annual report (Form 5500 Series), if applicable, and updated SPD. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. If applicable, the Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

You may be able to continue your participation in the Health FSA if there is a loss of coverage under the plan as a result of a qualifying event. If you are eligible to elect COBRA, you are required to pay for such coverage on a post-tax basis. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If you request a copy of Plan Documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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