FLEXIBLE BENEFIT PLAN

AMENDED & RESTATED

SUMMARY PLAN DESCRIPTION

ADOPTED BY:

CAROLINA HEALTH CENTERS, INC.

EFFECTIVE DATE:

JULY 1, 2020

SUMMARY PLAN DESCRIPTION

PART 1. GENERAL INFORMATION ABOUT THE PLAN

Your Employer (hereinafter "the Employer") sponsors an employee benefit plan known as the Flexible Benefit Plan ("the Plan") for you and all eligible Employees. The Plan allows you to choose from several different benefit programs ("Benefit Options") according to your individual needs and reduce your compensation before taxes are deducted to pay for the Benefit Options that you elect. This Plan helps you, because your payroll deductions for Benefit Options are non-taxable - you save all federal income tax, state income tax, and Social Security tax on the salary reductions.

This Summary Plan Description ("SPD") describes the Plan. The SPD describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a Plan Document into which the SPD has been incorporated. If there is a conflict between the Plan Document and the SPD, the Plan Document will govern. Capitalized terms in this SPD reflect important terms that are specifically defined. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under the Plan.

Participation in the Plan does not give any Participant the right to be retained in the employ of the Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator, who is identified in the Plan Information Summary.

Note: COVID-19 Relief may impact certain provisions and deadlines for the Plan outlined in this SPD. Generally, under this relief, the deadline to file claims and appeals is extended, the dates that claims must be incurred is extended, and certain election changes are allowable without a Change in Status Event. Where a provision or deadline outlined in this SPD is impacted by this relief, we have noted that COVID-19 Relief applies and provide a description of the applicable relief. For more information or if you have any questions, contact your Plan Administrator.

PART 2. FLEXIBLE BENEFIT PLAN SUMMARY

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible Employees to pay for Benefit Options with pre-tax contributions. The Benefit Options to which you may contribute with pre-tax contributions under the Plan are described in the Plan Information Summary. Rules regarding pre-tax contributions are described in more detail below.

Q-2. Who can participate in the Plan?

Each Employee of the Employer (or, where applicable, an Affiliated Employer) who satisfies the Plan's Eligibility Requirements will be eligible to participate in the Plan. If you meet these requirements, you may become a Participant on the Plan Entry Date. The Eligibility Requirements and the Plan Entry Date are described in the Plan Information Summary. Those Employees who participate in the Plan are called "Participants." As a Participant, you may use this Plan to pay for Benefit Options covering yourself and your Dependents as defined in Code Section 152 (except as otherwise defined in Code Section 105(b) and expanded, as applicable, by ERISA Section 714). The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Options. In other words, if you are eligible to participate in this Plan, it does not necessarily mean you are eligible to participate in all of the Benefit Options. For details regarding eligibility, benefit amounts, and premium schedules for each of the Benefit Options, please refer to the plan summary for each Benefit Option. If you do not have a summary for a particular Benefit Option, you should contact the Plan Administrator for information on how to obtain a copy.

Q-3. When does my participation in the Plan end?

Your coverage under the Plan ends on the earliest of the following to occur:

(i) The date that you make an election not to participate in accordance with this Plan Summary;
(ii) The date that you no longer satisfy the Eligibility Requirements of this Plan or all of the Benefit Options;
(iii) The date that you terminate employment with the Employer; or

(iv) The date that the Plan is either terminated or amended to exclude you or the class of Employees of which you are a member.

If your employment with the Employer is terminated during the Plan Year, or you otherwise cease to be eligible, your active participation in the Plan will automatically end, and you will not be able to make any more pre-tax contributions under the Plan, including any pre-tax contributions from severance pay except as otherwise provided pursuant to policies and procedures established by the Plan Administrator. If you are re-hired within the same Plan Year and are eligible for the Plan (or you become eligible again), you may make new elections if you are re-hired or become eligible again more than 30 days after your employment terminated or you otherwise lost eligibility (subject to any limitations imposed by the Benefit Option(s)). If you are re-hired or become eligible again within 30 days of termination, your Plan elections that were in effect when you terminated employment or lost eligibility will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

Q-4. How do I become a participant?

If you have satisfied the Eligibility Requirements, you become a Participant by signing an individual Salary Reduction Agreement (also referred to as an "Election Form") on which you agree to pay your share of the cost of the Benefit Options with pre-tax contributions. You will be provided a Salary Reduction Agreement on or before your Eligibility Date. You must complete the form and submit it to the Plan Administrator during one of the election periods described below. You may also enroll during the year if you previously elected not to participate and you experience an event described below that allows you to become a Participant during the year. If that occurs, you must complete an election change form during the Election Change Period (described below).

Automatic Enrollment for Pre-Tax Premiums: The Salary Reduction Agreement is primarily used for elections to participate in one or both of the Flexible Spending Accounts. For Pre-Tax Premiums, the Plan is designed to allow automatic enrollment. Regardless of the completion of the Salary Reduction Agreement, you will be automatically enrolled to have any applicable premiums (Benefit Options) deducted on a pre-tax basis. If for some reason you wish to waive the pre-tax option for eligible premiums, you may do so by completing a waiver form available from the Plan Administrator.

In some cases, the Employer may require you to pay your share of coverage for Benefit Option(s) you elect with pre-tax dollars. If that is the case, your election to participate in the Benefit Option(s) will constitute an election under this Plan.

Certain Employers utilize an electronic form of Salary Reduction Agreement. When such a method is utilized, you are required to complete the Salary Reduction Agreement in the manner specified. In order to utilize an electronic system, you may be required to sign an authorization form authorizing issuance of personal identification number ("PIN") and allowing such PIN to serve as your electronic signature when utilizing the system. The Plan Administrator and all parties involved with plan administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you. Also, the Plan Administrator or designated entity will keep an electronic record of all elections made through the use of such system.

Q-5. What are tax advantages and disadvantages of participating in the Plan?

By participating in the Plan, you save federal income tax, FICA (Social Security), and state income taxes on all salary reductions under the Plan. Consider the example and chart below to illustrate potential tax savings under the Plan. (Note: This example is based on the 2020 federal income tax bracket. For different years, please consult the applicable federal income tax bracket for more information.)

Example: You are married and have one child. The Employer pays for 80% of your medical insurance premiums and 40% of the premiums for family coverage. You pay $2,400 in premiums ($400 for your share of the employee-only premium, plus $2,000 for family coverage under the Employer's medical insurance plan). You earn $50,000 and your spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Plan		If you do not participate in the Plan
1. Gross income	$50,000		$50,000
2. Salary reductions for premiums	$2,400 (pre-tax)		$0
3. Adjusted Gross Income	$47,600		$50,000

4. Standard deduction	($24,800)		($24,800)
5. Taxable income	$22,800		$25,200
6. Federal income tax (Line 5 x applicable tax schedule)	($2,341)		($2,629)
7. FICA tax (7.65% x Line 3 amount)	($3,641)		($3,825)
8. After tax contributions	($0)		($2,400)
9. Pay after taxes & contributions	$41,618		$41,146
10. Take home pay difference	$472		

Plan participation will reduce the amount of your taxable compensation. Note that under some limited circumstances there could be a decrease in your Social Security benefits or other benefits (e.g., pension, disability, and life insurance) that are based on taxable compensation.

Q-6. What are the election periods for entering the Plan?

The Plan has three basic election periods: (i) the Initial Election Period, (ii) the Annual Election Period, and (iii) the Election Change Period, which is the period following the date you have a Change in Status Event. The following is a summary of the Initial Election Period and the Annual Election Period. The Election Change Period is described in Q-8.

6a. What is the Initial Election Period?

If you want to participate in the Plan when you are first hired or become eligible, you must enroll during the Initial Election Period described in the enrollment materials you receive. If you make an election during the Initial Election Period, your participation in this Plan will begin on the later of your Eligibility Date or the first pay period coinciding with or next following the date that your election is received. The effective date of coverage under the Benefit Options will be effective on the date established in the governing documents of the Benefit Options. The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Change in Status Event described in Q-8. below. If you do not make an election during the Initial Election Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. Failure to make an election under this Plan generally results in no coverage under the Benefit Options; however, the Employer may provide coverage under certain Benefit Options automatically. These automatic benefits are called “Default Benefits.” Any Default Benefits provided by your Employer will be identified in the enrollment material. In addition, your share of the contributions for such Default Benefits may be automatically withdrawn from your pay on a pre-tax basis. You will be notified in the enrollment material whether there will be a corresponding Pre-tax Contribution for such default benefits.

6b. What is the Annual Election Period?

The Plan also has an Annual Election Period during which you may enroll (if you did not enroll during the Initial Election Period) or change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the Plan Year unless you have a Change in Status Event. Where applicable, if you fail to complete, sign, and file a Salary Reduction Agreement during the Annual Election Period, you will be deemed to have elected not to participate in the Plan for the next Plan Year. In such case, you will not be able to enroll until the next Annual Election Period (unless you experience a mid-year Change in Status Event).

Alternatively, where applicable, if you fail to complete, sign, and file a Salary Reduction Agreement during the Annual Election Period, the Plan Administrator may deem you to have elected to continue participation in the Plan with the same Benefit Option elections that you had on the last day of the Plan Year in which the Annual Election period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an "Evergreen Election." If Evergreen Elections are in effect, you will be notified of such by the Plan Administrator prior to or during the Annual Election Period. *Special Rule for Flexible Spending Accounts*: Evergreen Elections do not apply to Flexible Spending Account elections. Consequently, you must make an election each Annual Election Period in order to contribute to a Flexible Spending Account during the next Plan Year.

The Plan Year is generally a 12-month period. The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. How is my Benefit Option coverage paid for under this Plan?

Unless you sign a waiver form, your share of contributions or premiums for all Benefit Options elected will be paid with pre-tax salary deductions. When you elect to participate both in a Benefit Option and this Plan, an amount equal to your share of the annual cost of those Benefit Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use pre-tax contributions, the deduction is made before any applicable federal and/or state taxes are withheld.

An Employer may choose to pay for a share of the cost of the Benefit Options you choose with Employer Contributions. The amount of Employer Contributions that is applied by the Employer towards the cost of the Benefit Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer's sole discretion at any time. The Employer Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Employer Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material or in the Plan Information Summary.

The Employer may provide you with Employer Contributions over which you have discretion to allocate the contributions to one or more Benefit Options available under the Plan. These elective employer contributions are called "Flexible Credits" or "Benefit Credits." The Flexible or Benefit Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment material.

Q-8. Under what circumstances can I change my election during the Plan Year?

Generally, you cannot change your election under this Plan during the Plan Year. There are, however, certain exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Plan or under all of the Benefit Options that you have chosen.

COVID-19 Relief (applicable to election changes during the 2020 calendar year)

Second, the IRS has provided relief due to the COVID-19 national emergency with respect to election changes under this Plan during the 2020 calendar year. Specifically, you may make the following election changes on a prospective basis without experiencing a Change in Status Event (as described below):

- With respect to employer-sponsored health coverage, on a prospective basis you may (1) make a new election if you initially declined coverage, (2) revoke an existing election and make a new election to enroll in a different health coverage sponsored by the Employer, or (3) revoke an election. If you revoke your election, you must attest in writing that you are enrolled or will immediately enroll in other health coverage;
- With respect to the Health FSA, on a prospective basis you may revoke an election, make a new election, or decrease/increase an existing election; and
- With respect to the Dependent Care FSA, on a prospective basis you make revoke an election, make a new election, or decrease/increase an existing election.

Third, you may voluntarily change your election during the Plan Year if you satisfy the following conditions:

(a) You experience a "Change in Status Event" that affects your eligibility under this Plan and/or a Benefit Option;
(b) You experience a significant cost or coverage change; and
(c) You complete and submit a written Election Change Form within 30 days of the event.

The Plan is designed to allow all election changes currently permitted by the IRS, as well as any events which the Plan Administrator determines are permitted under subsequent IRS regulations. The following is a summary of the applicable Change in Status Events, cost or coverage changes, or other applicable events that permit a mid-year election change. [Note: These rules do not apply to a Code Section 223 Health Savings Account offered under the Plan.]

1. **Changes in Status**. If one or more of the following Changes in Status occur, you may revoke your election and make a new election, provided that both the revocation and new election are on account of, and correspond with, the

Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:

- Change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse),
- Change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent),
- Any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a flexible benefit plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit,
- Event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student), or
- Change in your, your Spouse's, or your Dependent's place of residence.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for pre-tax contributions within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of, and corresponds with, the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of, and corresponds with, a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status Event if the event affects coverage eligibility (for the Dependent Care FSA, the event may also affect eligibility for the dependent care exclusion). A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of Dependents who may benefit under the plan.

In addition, you must also satisfy the following requirements in order to change your election:

- *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage, and Health FSA benefits), a special rule governs which type of election change is consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse; the death of your Spouse or your Dependent; or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage. Mike and Sharon subsequently divorce during the plan year. Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- However, you may increase your election to pay for COBRA coverage under the Employer's plan for yourself (if you still have pay) or any other individual who lost coverage but is a still a Dependent (e.g. a child who lives with you and to whom you provide over half of their support but who has lost eligibility under the Plan).

- *Gain of Coverage Eligibility under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's flexible benefit plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.
- *Dependent Care FSA Benefits*. With respect to the Dependent Care FSA benefit (when offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its flexible benefit plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year, when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits.* In the case of group term life insurance or disability income and dismemberment benefits, if you experience any Change in Status (as described above), you may elect to either increase or decrease coverage.

Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a flexible benefit plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights**. If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage, and eligibility for such coverage is subsequently lost due to certain reasons (legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days back to the date of the birth, adoption, or placement for adoption.

The Plan is designed to allow all special enrollment rights allowed by HIPAA and other federal regulations, including special enrollment that is provided when you are eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP). If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your Dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available. If you or your Dependents are <u>not</u> currently enrolled in Medicaid or CHIP, and you think you or any Dependents may be eligible for either of these programs, you can contact your State Medicaid or CHIP office. Details are also available at 1-877-KIDS NOW or www.insurekidsnow.gov. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your Dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

COVID-19 Relief: For the period beginning March 1, 2020 and ending 60 days after the announced end of the COVID-19 national emergency, the 30-day period (or 60-day period, if applicable) to request HIPAA special enrollment is disregarded. These deadlines are suspended during this period, providing additional time to request special enrollment after the announced end of the national emergency.

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Please refer to the group health plan description for an explanation of other special enrollment rights. Contact the Plan Administrator if you believe you may qualify for a special enrollment right based on your situation (or that of your Dependent(s)).

3. **Certain Judgments, Decrees, and Orders**. If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the Plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If the Plan Administrator notifies you that the cost of your coverage under the Plan significantly increases or decreases during the Plan Year, regardless of whether the cost change results from action by you (such as switching from full-time to part-time) or the Employer (such as reducing the amount of Employer contributions for a certain class of Employees), you may make certain election changes. If the cost significantly increases, you may choose (a) to make an increase in your contributions, (b) revoke your election and receive coverage under another Benefit Option which provides similar coverage, or (c) drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For insignificant increases or decreases in the cost of Benefit Options, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator (in its sole discretion) will determine whether the requirements of this Part are met. The Change in Cost provisions do not apply to Health FSA benefits.

> *Example*: Employee is covered under an indemnity option of his employer's health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Option which provides similar coverage. If the change amounts to a complete loss of coverage, you may drop coverage if no other similar coverage is available. If the Plan adds or significantly improves a Benefit Option during the Plan Year, you may revoke your election and elect to receive, on a prospective basis, coverage provided by the new or significantly improved option, as long as the new or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage which is different from the period of coverage under the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator (in its sole discretion) will determine whether the requirements of this Part are satisfied. The Change in Coverage provisions do not apply to Health FSA benefits.

7. **Qualifying Event for Health Insurance Marketplace Enrollment.** In 2014, pursuant to the Affordable Care Act, the Health Insurance Marketplace ("Marketplace") opened as a new option for individuals to secure health insurance coverage. Since the annual enrollment period for the Marketplace is different than the Annual Election Period under this Plan, the IRS allows the Plan to recognize a qualifying event for Employees that wish to revoke an election for group health insurance coverage and enroll in the Marketplace. Accordingly, the Plan will allow the following specific changes:

- An Employee who made an election for group health insurance coverage for any Plan Year may prospectively revoke his/her election in order to enroll in coverage at the Marketplace during the Marketplace annual open enrollment period, or
- An Employee who made an election for group health coverage for any Plan Year may prospectively revoke his/her election in order to enroll in coverage during a special election period for the Marketplace.

The election changes allowed in accordance with these Marketplace qualifying event options include changes for a Spouse or Dependent(s). Only election changes to the group health insurance plan are permitted. No election changes are permitted for other Benefit Options.

Other Election Rules: With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospectively effective from the date of the election or such later time as determined by the Plan Administrator. Additionally, the Plan's Administrator reserves the right to adjust or modify your pre-tax election(s) during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the IRS Code) and such a mid-year adjustment is necessary to prevent the Plan from failing applicable non-discrimination testing required by IRS law**.**

Also, an election under this Plan may be modified during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the applicable federal income tax law**.**

If coverage under a Benefit Option ends, the corresponding pre-tax contributions for that coverage will automatically end. No election is needed to stop the contributions.

Q-9. What happens to my participation under the Plan if I take a leave of absence?

The following is a general summary of the rules regarding participation in the Plan (and the Benefit Options) during a leave of absence. In general, beginning of a leave of absence constitutes a qualifying event that allows a Participant to make certain election changes consistent with the leave. If coverage is to be continued, it must be paid for in accordance with the Plan (see below). The specific election changes that you can make under this Plan upon a leave of absence are described here and in the Benefit Option summaries for each included benefit. If you have any questions about how a particular leave of absence scenario affects your benefits and pre-tax elections, contact the Plan Administrator.

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA"), the Employer will continue to maintain your Benefit Options that provide health coverage on the same terms and conditions as though you were still active to the extent required by FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all health coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with pre-tax contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:

(i) With after-tax dollars while you are on leave;

(ii) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with pre-tax contributions from your pre-leave pay by making a special election to that effect before the date such pay would normally be made available to you. However, pre-payments of pre-

tax contributions may not be utilized to fund coverage during the next Plan Year (except as otherwise permitted by law); or

(iii) By other arrangements established by the Plan Administrator.

The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA, and the Employer's internal policies and procedures regarding leaves of absence and will be applied uniformly to all Participants.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan and the Benefit Option(s) upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) The Plan Administrator may in its discretion continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Option offered under this Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Option, the election change rules described herein will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-10. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the Plan at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of the Plan.

Q-11. What happens if my request for a benefit under this Plan (e.g., an election change or other issue relevant to pre-tax contributions) is denied?

You will have the right to a full and fair review process. You should refer to the Claims Review Procedures Appendix for a detailed summary of the Claims Procedures under this Plan.

Q-12. Governing Law and Plan Interpretation

The Plan is governed by the IRS Code. The Plan Administrator will interpret and administer it in accordance with the Code.

PART 3. BENEFITS

During any Plan Year, the maximum salary reduction amount a Participant can elect cannot exceed the sum of the cost of the Benefit Options offered under this Plan. Any part of this maximum salary reduction amount that you do not elect will be paid to you as regular, taxable compensation. Except to the extent set forth in the Enrollment material, any Benefit Credits not used towards the cost of Benefit Options made available under the Plan will revert back to the employer.

PART 4. HEALTH FSA SUMMARY

Q-1. What is the Health FSA and who can participate?

The Health FSA is an account that allows you to set aside pre-tax dollars from your pay to be reimbursed for eligible out-of-pocket medical, dental, and vision expenses. Employees who satisfy Eligibility Requirements are eligible to participate on the Plan Entry Date. Eligibility Requirements and Plan Entry Date are described in the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the eligibility requirements, you become a Participant in the Health FSA by electing this benefit during the Initial or Annual Election Periods. If you have previously made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you will have the same election for the next Plan Year. Evergreen Elections do not apply to the Health FSA.

You may also become a participant under the COVID-19 Relief applicable to election changes during the 2020 calendar year or if you experience a Change in Status Event that permits you to enroll mid-year. See Part 2 for more information on the COVID-19 Relief applicable to election changes.

Once you become a Participant, your Eligible Dependents also become covered. For purposes of the Health FSA, Eligible Dependents are the following:

(i) Your Spouse; and
(ii) Any other individual(s) who would qualify as a tax Dependent under Code Section 105(b), expanded as applicable by ERISA Section 714.

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health FSA does not otherwise provide. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree, or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health FSA, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain without charge a copy of the Plan's procedures for qualified medical child support orders.

NOTE: Employee Only or Employee-Plus-Child(ren) Election: Your participation in this Health FSA could disqualify your Spouse or Dependent(s) from establishing and making/receiving tax favored contributions to a health savings account (as defined in Code Section 223) unless you have elected the limited reimbursement option set forth below.

If your Spouse maintains a Code Section 223 Health Savings Account ("HSA") or wishes to establish an HSA, your participation in this Health FSA (to the extent reimbursement under this Health FSA is not restricted as described in Q-11 below) may cause your Spouse to be ineligible for an HSA if your Spouse or your Dependents are covered under this Health FSA. As a Participant, you have the option to elect an "Employee-Only" or "Employee-Plus-Children" Health FSA, in order to protect the eligibility of a Spouse or Dependents for the HSA. You may make such an election during the Initial Enrollment Period or during the Annual Election Period described in Q-2 above, or at the time of a qualifying event as described in Q-5 below. Neither the Employer nor anyone else has the authority to make this election on your behalf.

If you elect an "Employee-Only" Health FSA, only eligible expenses incurred by you may be reimbursed from the Health FSA. If you elect an "Employee-Plus-Children" Health FSA, only eligible expenses incurred by you or your qualifying Dependents (other than Spouse) may be reimbursed from the Health FSA.

Q-3. What is my Health FSA "account"?

If you elect to participate in the Health FSA, the Employer will establish a Health FSA account entry to keep a record of the reimbursements to which you are entitled, as well as the pre-tax contributions you elected to pay for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Health FSA are paid as needed from the Employer's general assets.

Q-4. When does coverage under the Health FSA end?

Your coverage under the Health FSA ends on the earlier of the following to occur:

(i) The date that you elect not to participate, in accordance with the Plan Summary;
(ii) The last day of the Plan Year, unless you make an election during the Annual Election Period;
(iii) The date that you no longer satisfy the Health FSA Eligibility Requirements;
(iv) The date that you terminate employment; or
(v) The date that the Plan is terminated or the date that the Plan is amended to exclude you or the class of eligible Employees of which you are a member.

You may be entitled to elect Continuation Coverage (as described below) under the Health FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on the earliest of the following to occur:

(i) The date your coverage ends;
(ii) The date that your Dependents cease to be eligible Dependents (e.g. you and your Spouse divorce);
(iii) The date the Plan is terminated or the date that the Plan is amended to exclude from coverage under the Health FSA the individual or the class of Dependents of which the individual is a member.

You and/or your covered Dependents may be entitled to continue coverage if coverage is lost for certain reasons. The continuation of coverage provisions are described in more detail below.

Q-5. Can I ever change my Health FSA election?

You can change your election under the Health FSA in the following situations:

(i) *For any reason during the Annual Election Period*. You can change your election during the Annual Election Period for any reason. The new election will be effective the first day of the new Plan Year.

(ii) *For any reason during the 2020 calendar year under the COVID-19 Relief applicable to election changes, on a prospective basis*. See Part 2 for more information on the COVID-19 Relief applicable to election changes.

(iii) *Following a Change in Status Event*. You may change your Health FSA election during the Plan Year only if you experience an applicable Change in Status Event. See Part 2 for more information on election changes. You may not make Health FSA election changes as a result of any cost or coverage changes.

Q-6. What happens to my Health FSA if I take an approved leave of absence?

Refer to Part 2 to determine what, if any, specific changes you can make during a leave of absence. If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at either (a) the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage), or (b) at the same coverage level that is reduced pro rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

Q-7. What is the maximum annual Health FSA reimbursement that I may elect under the Health FSA, and how much will it cost?

You may elect any annual reimbursement amount subject to the maximum annual Health FSA reimbursement Amount and Minimum Reimbursement Amount described in the Plan Information Summary. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Employer Contributions and/or Benefit Credits allocated to your Health FSA.

Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

Q-8. How are Health FSA reimbursement benefits paid for under this Plan?

When you complete the Salary Reduction Agreement, you specify the amount of Health FSA reimbursement you wish to pay for with pre-tax contributions and/or Benefit Credits, to the extent available. Your enrollment material will indicate if Benefit Credits are available for Health FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro rata share of the annual contribution, reduced by any Benefit Credits allocated to your Health FSA.

If your claim for benefits is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways: (i) a check made payable to you (all benefits are paid as needed from the Employer's assets); (ii) electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the Participant); (iii) if an electronic payment card is used, payment may be made directly to the health care provider at the point of purchase (subject to the Plan's right of reimbursement).

Q-9. What amounts will be available for Health FSA at any particular time during the Plan Year?

So long as coverage is effective, the full, annual amount of Health FSA reimbursement you have elected, reduced by the amount of previous Health FSA reimbursements received during the Year, will be available at any time during the Plan Year, without regard to how much you have contributed. This is known as "annualization" or the Universal Coverage Rule.

Q-10. How do I receive reimbursement under the Health FSA?

Under this Health FSA, you have two reimbursement options. You can complete and submit a claim for reimbursement (see "Traditional Claims" below for more information). Alternatively, if applicable, you can use an electronic payment card ("Debit Card") to pay for the expense directly at the point of purchase or health care provider. In order to be eligible for the Debit Card, you must agree to abide by the terms and conditions of the electronic payment card program (the "Program") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how these options work.

Traditional Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan's Plan Service Provider by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Plan Service Provider, or you may utilize an electronic form available on the Plan Service Provider's website (online claim option) or mobile application. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

1. Name of person receiving service
2. Name and address of service provider
3. Nature of service or supplies (drug name if a prescription or over-the-counter medication)
4. Amount of reimbursable expense under the plan
5. Date(s) of service

The Plan Service Provider will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Medical Expense, you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the Claim Runout Period following the end of the Plan Year (or if applicable, the Terminated Employee Runout Period following the date that you cease to be a participant). The Claim Runout Period (along with the Terminated Employee Claim Runout Period) is described in the Plan Information Summary.

Electronic Payment Card ("Debit Card"). Alternatively, if enabled as a Plan option you may be able to use an approved Debit Card to pay the expense. In order to be eligible for the Debit Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program"), as set forth in Part 6 and in the Cardholder Agreement, including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.

File Import Option: Certain plans allow or include a special claims processing option. Where applicable, you may have a claim submitted by means of a provider supplied electronic claim file ("import"). In other words, the claim is provided directly to the Plan Service Provider by the provider or health plan. In that case, you do not need to file a claim with the Plan Service Provider; it is deemed filed when the Plan Service Provider receives the claim. You will be notified in the enrollment material of this Plan or the applicable Benefit Option if claims will be provided directly to the Plan Service

Provider of this Plan. If you elect this option when made available to you, you must hereby agree not to seek reimbursement for an imported claim from any other source.

Q-11. What is an Eligible Medical Expense?

An Eligible Medical Expense is an expense that has been incurred by you and/or your eligible Dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d);
- 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. This includes, but is not limited to, both prescription drugs and over-the-counter items and devices.

Not every health-related expense you or your eligible Dependents incur constitutes an expense for "medical care" per the IRS definition. For example, an expense is not for medical care if it is merely for the beneficial health of you or an eligible Dependent (e.g. vitamins or nutritional supplements 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 be required to provide additional documentation from a health provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. "Stockpiling" of over-the-counter items is not permitted to the extent that a certain quantity of such items cannot reasonably be deemed to be used within the Plan Year. According to the Code, there must be a reasonable expectation that such items could be used during the Plan Year.

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

- Health insurance premiums;
- Expenses incurred for qualified long-term care services; and
- Any other expenses that are specifically excluded by the Plan Administrator (these exclusions, if any, will be listed here or in the Plan Information Summary).

If you currently maintain or wish to establish a personal Health Savings Account, you may be able to make an election to limit the scope of your FSA coverage as set forth below and in the Plan Information Summary.

According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), a Health FSA participant (and any covered Dependents) will not be able to make/receive tax favored contributions to a Code Section 223 HSA unless the scope of expenses eligible for reimbursement under the Health FSA is limited to the following expenses (to the extent such expenses constitute "medical care" as defined in Code Section 213(d)):

(i) Services or treatments for dental care (excluding premiums)
(ii) Services or treatments for vision care (excluding premiums)

You may elect to limit the scope of reimbursement during Initial and/or Annual Enrollment Period.

Q-12. When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred during the Plan Year and while you are a participant in the Plan. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. You may not be reimbursed for any expenses arising before the Health FSA becomes effective, before your Salary Reduction Agreement (Election Form) becomes effective, or for any expenses incurred after the close of the Plan Year or after a separation from service or loss of eligibility (except for expenses incurred during a COBRA continuation period).

COVID-19 Relief: Due to the COVID-19 national emergency, the IRS has provided relief extending the dates that Health FSA claims may be incurred. Any unused amounts remaining in your Health FSA as of the end of a grace period (if adopted) or Plan Year ending in 2020, may be used to pay or reimburse Eligible Medical Expenses incurred through December 31, 2020.

If the Employer has adopted a grace period, you may also use amounts allocated to the Health FSA that are unused at the end of the Plan Year for expenses incurred during the applicable grace period following the end of the Plan Year. Where applicable, the grace period allows Participants a period of time starting with the first day after the end of the Plan Year and continuing until a date not to exceed two months and 15 days after the end of the Plan Year. Eligible Medical Expenses incurred during the grace period may be reimbursed from any unused amounts in the Participant's Health FSA in the Plan Year that ended on the day before the grace period. Any amounts incurred after the previous Plan Year funds were exhausted would be reimbursable under the current Plan Year to the extent they would if the grace period were not in effect. The terms of the grace period, if adopted, are described in the Plan Information Summary.

If the Employer has adopted the carryover provision, you may also use limited amounts allocated to the Health FSA that are unused at the end of the current Plan Year for expenses incurred during following Plan Year. Where applicable, the carryover allows Participants to carry forward Health FSA amounts for reimbursement of Eligible Medical Expenses in the following Plan Year. Unused FSA amounts will also remain eligible for reimbursement of expenses incurred during the current Plan Year, if submitted during the Claim Runout Period. At the end of the Claim Runout Period, all unused FSA amounts exceeding the allowable carryover maximum will be forfeited. The terms of the carryover, if applicable, are listed in the Plan Information Summary.

Q-13. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for Health FSA reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual coverage level you have elected. Any amount allocated to a Health FSA will be forfeited to the Employer if it has not been applied to provide reimbursement for expenses incurred during the Plan Year, or during the extended dates claims may be incurred under the COVID-19 Relief the described above in Q-12, that are submitted for reimbursement within the Claim Runout Period described in the Plan Information Summary. Amounts so forfeited shall be used to offset administrative expenses or applied in a manner that is consistent with applicable rules and regulations.

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Health FSA that are unused at the end of the Plan Year may be used to reimburse expenses incurred during the grace period following the end of the Plan Year. Any amounts not used for expenses incurred during the Plan Year or grace period will be forfeited.

If the Employer has adopted a carryover provision for the current Plan Year, amounts allocated to the Health FSA up to the allowable carryover maximum that are unused at the end of the current Plan Year or during the extended dates claims may be incurred under the COVID-19 Relief the described above in Q-12, may be used to reimburse expenses incurred during the following Plan Year. Any amounts in excess of the allowable carryover not used for expenses incurred during the current Plan Year will be forfeited. The terms of the carryover, if applicable, are listed in the Plan Information Summary.

Q-14. What happens if a Claim for Benefits under the Health FSA is denied?

You will have the right to a full and fair review process. You should refer to the Claims Review Procedure Appendix, Appendix I, for a detailed summary of the Claims Procedures under this Plan.

Q-15. What happens to unclaimed Health FSA reimbursements?

Any Health FSA reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) within 90 days after reimbursement is made shall be forfeited.

Q-16. What is COBRA continuation coverage?

COVID-19 Relief: For the period beginning March 1, 2020 and ending 60 days after the announced end of the COVID-19 national emergency, the following COBRA deadlines (generally discussed below) are disregarded:

- Deadline to elect COBRA;
- Deadline for qualified beneficiary to make a first premium payment or ongoing premium payment (deadline + grace period);
- Deadline for individual or employer to notify plan of a qualifying event; and
- Deadline for individual to notify the plan of a determination of disability.

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage ("continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to this Health FSA unless the Employer sponsoring the Health FSA is not subject to these rules (e.g., the employer is a "small employer" under the Code, or the Health FSA is a church-sponsored Plan). The Plan Administrator will inform you whether the Employer is subject to federal COBRA continuation rules. These rules are intended to summarize the continuation rights set forth under federal law. Should you be eligible for COBRA continuation of your Health FSA upon termination of coverage, you will be notified by the Plan upon termination of coverage. If you have other questions regarding your continuation rights, see the Plan Administrator.

When Coverage May Be Continued

Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A Qualified Beneficiary is the Participant, covered Spouse, or covered Dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee's Termination of employment or reduction in hours of employment	√	√	√
2. Divorce or Legal Separation		√	
3. Child ceasing to be an eligible Dependent			√
4. Death of the covered Employee		√	√

NOTE: Notwithstanding the above, you do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. Specifically, if you terminated Health FSA coverage with a negative balance (less contributions than reimbursements), you will not be eligible to continue your Health FSA through the end of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active Employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Health FSA upon the occurrence of any event that permits a similarly situated active Employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the COBRA Administrator (if a COBRA Administrator is not identified in the Plan Information Summary, then contact the Plan Administrator) in writing of a divorce, legal separation, or a child losing Dependent status under the Plan within 60 days of the later of (i) date of the event or (ii) the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date of the qualifying event and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will then notify you that you have

the right to choose continuation coverage by sending you the appropriate election forms. Notice to an Employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g. divorce decree).

An Employee or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) and return it to the COBRA Administrator identified in the Plan Information Summary within 60 days from the date you would lose coverage for one of the reasons described above, or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month. However, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-Elective contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (if your payment is insufficient by the lesser of 10% of the required premium or $50, you will be given 30 days to cure the shortfall);
- if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- if you become entitled to Medicare; or
- if the Employer no longer provides group health coverage to any of its Employees.

Q-17. What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year or the extended dates claims may be incurred under the COVID-19 Relief described above in Q-12, it is determined that you have received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been properly substantiated during the Plan Year as set forth in this SPD, or reimbursements have been made in error for any reason, the Plan Administrator may recoup the excess reimbursements in one of the following ways: (i) the Plan Administrator will notify you of the excess amount, and you will be required to repay the excess amount to the Employer immediately after receipt of the notification; (ii) the Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or (iii) the Plan Administrator may withhold such amounts from your pay (to the extent permitted by applicable law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth above, the Plan Administrator will notify the Employer of the inability to collect the funds, and such excess reimbursements will be reported as taxable income to you.

Q-18. Will my health information be kept confidential?

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.

Q-19. How long will the Health FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason.

Q-20. How does this Health FSA interact with a Health Reimbursement Arrangement Sponsored by the Employer? (If Applicable)

Typically, a Health FSA is the payor of last resort. This means the Health FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in a Health Reimbursement Arrangement ("HRA") or other qualified Section 105 plan sponsored by the Employer that covers expenses also covered by this Health FSA, the employer may require the Health FSA pay first, rather than the HRA. If the Health FSA pays first, you must exhaust your Health FSA before using funds allocated to your HRA. Your HRA enrollment material will let you know whether the HRA or the Health FSA pays first.

MISCELLANEOUS RIGHTS UNDER THE HEALTH FSA

ERISA Rights

The Health FSA is a welfare benefit plan governed by the Employee Retirement Income Security Act ("ERISA") if your employer is a private employer and not exempt as a church or governmental entity. You are entitled to certain rights and protections outlined by 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 or other specified locations all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest Annual Report (Form 5500) filed 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 all documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest Annual Report (Form 5500) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report (Summary Annual Report).

Continue Group Health Plan Coverage

As described above, you may continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You will have to pay for such coverage.

This Plan is designed to meet the FSA exemption from HIPAA's portability rules. However, to the extent the Health FSA is subject to portability rules, the following will apply:

You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. If you are eligible for this reduction or elimination, you will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

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 "fiduciaries" of the Plan have a duty to do so prudently and in the interest of the 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 welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA plan is denied in whole or in part, you will receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and have the claim reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 the 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., 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.

Application of Additional Federal Laws

The following federal laws apply to group health plans. As a group health plan, the Health FSA may be covered by these laws to the extent it is a non-excepted benefit under the HIPAA portability rules. If you have any questions about whether these or other laws impact your Health FSA coverage or other group benefits, contact the Plan 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).

Parity in Mental Health and Substance Abuse Disorder Benefits

Group health plans with annual or lifetime limits for medical/surgical benefits generally must apply equivalent limits for mental health benefits and substance abuse disorder benefits.

Genetic Information Nondiscrimination Act of 2008

Group health plans may not (a) request or require individuals or their family members to undergo genetic testing, (b) use genetic information to determine eligibility for coverage or impose preexisting condition exclusions, collect genetic information for underwriting purposes or with respect to any individual prior to enrollment or coverage, and (d) adjust any

premium or contribution on the basis of genetic information. Group health plans also may not discriminate against employees with respect to compensation, terms, conditions, or privileges of employment based on genetic information.

PART 5. DEPENDENT CARE FSA COMPONENT SUMMARY

Q-1. What is the Dependent Care FSA and who can participate?

The Dependent Care FSA is an account that allows you to set aside pre-tax dollars from your pay to be reimbursed for work-related childcare expenses. Each Employee who satisfies the Eligibility Requirements is eligible to participate in the Dependent Care FSA on the Plan Entry Date. The Eligibility Requirements and the Plan Entry Date are described in the Plan Information Summary.

Q-2. How do I become a Participant?

If you have satisfied the Eligibility Requirements, you become a participant in the Dependent Care FSA by electing Dependent Care FSA reimbursement benefits during the Initial or Annual Election Periods. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen Elections do not apply to Dependent Care FSA elections.
You may become a participant under the COVID-19 Relief applicable to election changes during the 2020 calendar year or if you have a Change in Status Event or cost/coverage change that permits you to enroll mid-year. See Part 2 for more information on the COVID-19 Relief applicable to election changes.

Q-3. What is my Dependent Care FSA "account"?

If you elect to participate in the Dependent Care FSA, the Employer will establish an account entry to 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 Dependent Care FSA are paid as needed from the Employer's general assets.

Q-4. When does my coverage under the Dependent Care FSA end?

Your coverage under the Dependent Care FSA ends on the earlier of the following to occur:

(i) The date that you elect not to participate, in accordance with the Plan Summary;
(ii) The last day of the Plan Year, unless you make an election during the Annual Election Period;
(iii) The date that you no longer satisfy the Dependent Care FSA Eligibility Requirements;
(iv) The date that you terminate employment; or
(v) The date that the Plan is terminated or you, or the class of eligible Employees of which you are a member, are specifically excluded from the Plan.

If you terminate employment or cease to be eligible during the Plan Year, you may submit Eligible Day Care Expenses incurred after the date of termination up to the amount of your Dependent Care Account to the extent set forth in the Plan Information Summary (through the end of the Terminated Employee Claim Runout Period).

Q-5. Can I ever change my Dependent Care FSA election?

You can change your election under the Dependent Care FSA in the following situations:

(i) *For any reason during the Annual Election Period*. You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

(ii) *For any reason during the 2020 calendar year under the COVID-19 Relief applicable to election changes, on a prospective basis*. See Part 2 for more information on the COVID-19 Relief applicable to election changes.

(iii) *Following a Change in Status Event or Cost or Coverage Change*. You may change your Dependent Care FSA election during the Plan Year if you experience an applicable Change in Status Event or there is a significant cost or coverage change. Change in Status Events for the Dependent Care FSA are not necessarily the same as those for the Health Care FSA. If you have experienced a change in cost, change in provider, or change in

circumstances that affects your dependent care coverage, you may be entitled to change your election mid-year. Contact the Plan Administrator for more information.

Q-6. What happens to my Dependent Care FSA if I take an unpaid leave of absence?

Refer to Part 2 to determine what, if any, specific changes you can make during a leave of absence.

Q-7. What is the maximum annual reimbursement that I may elect under the Dependent Care FSA?

The annual amount cannot exceed the maximum Dependent Care FSA reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently $5,000 per Plan Year if you:

- are married and file a joint return;
- are married but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or
- are single.

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care FSA reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax free basis during the Plan Year cannot exceed the lesser of your earned income (as defined in Code Section 32) or your Spouse's earned income.

Your Spouse will be deemed to have earned income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your Spouse is

(i) physically or mentally incapable of caring for himself or herself, or
(ii) a full-time student (as defined by Code Section 21).

Q-8. How Do I Pay for Dependent Care FSA reimbursements?

When you complete the Salary Reduction Agreement, you specify the amount of Dependent Care FSA reimbursement you wish to pay for with pre-tax contributions and/or Benefit Credits. Thereafter, each paycheck will be reduced by an amount equal to a pro rata share of the annual contribution, reduced by any Benefit Credits allocated to your Dependent Care Account.

If your claim for benefits is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways: (i) a check made payable to you (all benefits are paid as needed from the Employer's general assets); (ii) electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the Participant); or (iii) if an electronic payment card is used, payment may be made directly to the health care provider at the point of purchase (subject to the Plan's right of reimbursement).

Q-9. What is an Eligible Day Care Expense for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses (Eligible Day Care Expenses). Generally, an expense must meet all of the following conditions for it to be an Eligible Employment Related Expense:

(1) The expense is incurred (expenses are considered incurred only if the service has already occurred) for services rendered after the date of your election to receive Dependent Care FSA reimbursement benefits and during the calendar year to which it applies. **Note**: Due to the COVID-19 national emergency, the IRS has provided relief extending the dates that Dependent Care FSA claims may be incurred as discussed further below.

(2) Each individual for whom you incur the expense is a "Qualifying Individual." A Qualifying Individual is:

(i) An individual age 12 or under who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her support; or
(ii) a Spouse or other tax Dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

Note: there is a special rule for children of divorced parents. The child is a qualifying individual of the "custodial parent," as defined in Code Section 152(e).

(3) The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

(4) If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

(5) If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

(6) The expense is not paid or payable to a "child" (as defined in Code Section 152(f)(1)) of yours who is under age 19 by the end of the year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

(7) You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

In order to exclude from income amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address, and taxpayer identification number of the dependent care service provider on your federal income tax return. You are encouraged to consult your personal tax advisor or IRS Publication 17 for further guidance as to what is or is not an Eligible Employment Related Expense if you have any questions.

Q-10. How do I receive reimbursement under the Dependent Care FSA?

Under this Dependent Care FSA, you have two reimbursement options. You can complete and submit a claim for reimbursement (see "Traditional Claims" below for more information). Alternatively, if applicable, you can use an electronic payment card ("Debit Card") to pay for the expense directly at the point of purchase or health care provider. In order to be eligible for the Debit Card, you must agree to abide by the terms and conditions of the electronic payment card program (the "Program") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how these options work.

Traditional Claims: When you incur an Eligible Day Care Expense, you file a claim with the Plan Service Provider by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Plan Service Provider, or you may utilize an electronic form available on the Plan Service Provider's website (online claim option) or mobile application. You must include with your Request for Reimbursement Form a written statement from an independent third party associated with each expense that indicates the following:

1. Name of person receiving service
2. Name and address of service provider
3. Amount of reimbursable expense under the plan
4. Date(s) of service

The Plan Service Provider will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Day Care Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Day Care Expense, you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Day Care Expenses during the Plan Year in which they were incurred or during the Claim Runout Period following the end of the Plan Year (or if applicable, the Terminated Employee Runout Period following the date that you cease to be a participant). The Claim Runout Period (along with the Terminated Employee Claim Runout Period) is described in the Plan Information Summary.

Electronic Payment Card ("Debit Card"). If enabled as a Plan option, you may be able to use an approved Debit Card to pay the expense. In order to be eligible for the Debit Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program"), as set forth in Part 6 and in the Cardholder Agreement, including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.

If your claim was for an amount that was more than your current Dependent Care Account balance, the excess part of the claim will be carried over into following months and paid out as your balance becomes adequate. Remember that you cannot be reimbursed for any total expenses above your available balance to your Dependent Care Account. You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

It is not necessary that you have actually paid an amount due for Eligible Employment Related Expenses - only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

Q-11. When must the expenses be incurred in order to receive reimbursement?

Eligible Day Care Expenses must be incurred during the Plan Year. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year (except for eligible Spend-Down expenses), or after your participation in the Dependent Care FSA ends.

COVID-19 Relief: Due to the COVID-19 national emergency, the IRS has provided relief extending the dates that Dependent Care FSA claims may be incurred. Any unused amounts remaining in your Dependent Care FSA as of the end of a Plan Year ending in 2020 may be used to pay or reimburse Eligible Day Care Expenses incurred through December 31, 2020.

Q-12. What if the Eligible Day Care Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care FSA reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related Expenses you have incurred and the annual Dependent Care FSA reimbursement you have elected and paid for. Any amount credited to a Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year by the end of the Claim Runout Period following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs or as otherwise permitted under applicable law.

Q-13. Will I be taxed on the Dependent Care FSA reimbursements I receive?

You will not normally be taxed on your Dependent Care FSA reimbursements so long as your family's aggregate (under this Dependent Care FSA and/or another employer's dependent care FSA) does not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-14. If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care 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 Dependent Care FSA, although the balance of your Eligible Employment Related Expenses may be eligible for the dependent care credit.

Q-15. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. 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 income over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same

expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

Q-16. What happens to unclaimed Dependent Care FSA reimbursements?

Any Dependent Care FSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Employment Related Expense was incurred shall be forfeited.

Q-17. What happens if my claim for reimbursement under the Dependent Care FSA is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan

Q-18. What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year or the extended dates claims may be incurred under the COVID-19 Relief described above in Q-11,, it is determined that you have received payments under this Dependent Care FSA that exceed the amount of Eligible Employment Related Expenses that have been properly substantiated during the Plan Year as set forth in this SPD, or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways: (i) the Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer within sixty (60) days of receipt of the notification; (ii) the Plan Administrator may offset the excess reimbursement against any other eligible Employment Related Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or (iii) the Plan Administrator may withhold such amounts from your pay (to the extent permitted by applicable law). If the Plan Administrator is unable to recoup the excess reimbursements by the means set forth in (i) – (iii), the Plan Administrator will notify the Employer that the funds could not be recouped, and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse tax consequences to you.

Q-19. How long will the Dependent Care FSA remain in effect?

The Employer expects to maintain the Plan indefinitely, but it may modify or terminate the program at any time.

PART 6. DEBIT CARD REIMBURSEMENT

If implemented by the Employer, an Electronic Payment Card ("Debit Card" or "the Card") allows you to pay for expenses that are reimbursable under the Health FSA or Dependent Care FSA. This section only applies if your Employer has implemented the Debit Card option.

This is a summary of how the Debit Card works:

(a) *You must be an active Participant in the Health FSA or Dependent Care FSA to use the Card.* In order to be eligible for the Debit Card, you must make a current election, and you must agree to abide by the terms and conditions of the Program as set forth here and in the Electronic Payment Cardholder Agreement ("Cardholder Agreement"), including any fees applicable to participate in the Program, any limitations as to card usage (i.e., it cannot be used at all MasterCard® acceptance locations and has no cash access), and the Plan's right to withhold and offset for ineligible claims. A Cardholder Agreement will be provided to you when your card is provided. The Card will be effective the first day of each Plan Year unless you affirmatively opt-out of the Program during the Annual Election Period. The Cardholder Agreement is incorporated as part of the terms and conditions of this SPD.

(b) *The Card will be deactivated when employment or coverage terminates.* The Card will be turned off when you terminate employment or end coverage under the Plan for any reason. You may not use the Card during any applicable COBRA continuation coverage period.

(c) *You must certify proper use of the Card.* As specified in the Cardholder Agreement, by making an FSA election and activating your card, you certify that the amounts charged will only be for Eligible Medical Expenses or Eligible Day Care Expenses incurred by you, your Spouse, and your Dependents as applicable.

You also certify that you have not been reimbursed for the expense and that you will not seek reimbursement from any other source. Failure to abide by this certification will result in termination of card privileges.

(d) *Card Reimbursement is limited to specific providers.* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, health providers, etc.). As outlined in the Cardholder Agreement, the Card may be used at many retail locations that sell medical items and have implemented a retail processing system known as "IIAS," but not all retail merchants have implemented the system, and the card will not work at all MasterCard® acceptance locations.

Use of the card for Dependent Care FSA expenses is limited to merchants who are day care providers. For both FSA options, IRS rules determine what providers may accept the Card. If you have any questions about where the Card may be used, contact the Plan Service Provider.

(e) *You swipe the Card at the provider as you do any other credit or debit card.* When you incur an Eligible Medical Expense or Eligible Day Care Expense at a qualified location, you swipe the card much like you would a typical credit or debit card. The provider is paid for the expense by the Card (up to the maximum reimbursement amount available). Each time you swipe the card, you are certifying that the expense for which payment is being made is eligible and that you have not been reimbursed from any other source nor will seek reimbursement from another source.

(f) *You must obtain and retain a receipt/statement each time you swipe the Card.* Per IRS rules, you must obtain a third-party statement or documentation from the provider (e.g., invoice, receipt, charge details, etc.) each time you swipe the Card. Documentation must include the following information:

- The nature of the expense (type of service or treatment was provided);
- The date the expense was incurred; and
- The amount of the expense.

You must retain documentation for the duration of the Plan Year in which the expense is incurred. Even though payment will be made pursuant to the Card Agreement, a written third-party statement may be required to be submitted in order to substantiate the expense. You will receive written notice from the Plan Service Provider when a third-party statement is required. If requested, you must provide the third-party statement within the specified time period (typically as soon as possible but no later than 28 days).

(g) *There are situations where the third-party statement will not be required to be provided (Health FSA only).* There are situations in which you will not be required to provide documentation to the Plan Service Provider. Such instances of "auto-adjudication" include swiping a card at an authorized medical service provider for an amount equal to your group health plan co-pay for a doctor visit or specialist visit. Other auto-adjudication scenarios include swipes for prescriptions and eligible items at retail merchants who have implemented the IIAS system. The Cardholder Agreement includes more information about auto-adjudication.

Note: You must obtain the third-party receipt for ALL card transactions when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Plan Service Provider or the IRS requests it.

(h) *You must refund any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Plan Service Provider, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is determined by the Plan (typically 28 days). If you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against any future eligible claims under the Plan. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay, or the remaining unpaid amount will be included in your gross income as taxable wages. The Employer reserves all rights under the Cardholder Agreement to seek repayment of any Plan funds improperly paid.

(i) *Using the Card is not required – you still have the option of using a traditional claim for reimbursement.* You have the choice as to how to submit your FSA claims for reimbursement. If you elect to not use the Card, you may submit claims under the traditional claims approach. The only limitation is that claims for which the Card has been used cannot also be submitted as traditional claims for reimbursement. Certainly, if you have elected not to use the Card, you retain the right to use the traditional claim approach for all claims.

PART 7. PLAN INFORMATION SUMMARY

Employer Details

Name of Organization:	Carolina Health Centers, Inc.
Plan Administrator:	Carolina Health Centers, Inc.
Acceptance of Legal Process:	Carolina Health Centers, Inc.
Federal Employer ID Number:	57-0650154
Address of Plan Sponsor:	313 Main Street, Suite B, Greenwood, SC 29646-2757

Plan Details

Plan Name:	Carolina Health Centers, Inc. Flexible Benefits Plan
Plan Number:	501
Effective Date of this Amended SPD:	July 1, 2020
Plan Year Basis:	1/1 - 12/31

Plan Administration

As Plan Sponsor and Plan Administrator, the Employer, in conjunction with the appointed Plan Service Provider, will perform the functions of accounting, recordkeeping, changes of participant status, and any election or reporting requirements of the IRS Code.

Plan Funding Arrangement

The Plan is entirely self-funded, with no trust arrangement.

Eligibility Requirements

To be eligible, an Employee must be active and full-time with a customary weekly employment schedule of equal to or greater than 30 hours. Any Employee covered by a collective bargaining agreement is not eligible.

The Eligibility Waiting Period is as follows for each Plan component:

Pre-Tax Premiums	60 days*
Dependent Care FSA	60 days*
Health FSA	60 days*

The Plan Entry Date is when an Employee meeting the eligibility requirements may begin participation. The Plan Entry Date is: First day of the following month after Eligibility Waiting Period.

* Note: A special eligibility entry rule applies for Employees designated as management, providers, or pharmacists. These Employees are eligible after a 0-day waiting period.

Benefit Options

The following Benefit Options, which are sponsored and maintained by the Employer for the benefit of Employees, are offered under the Plan. In the absence of a waiver, any Employee cost for premiums will be automatically deducted on a pre-tax basis.

Group Health Insurance
Group Dental Insurance
Health FSA
Dependent Care FSA

Benefits Excluded

The following benefits are specifically excluded from pre-tax coverage under this Plan:

Group Short Term Disability Insurance
Group Long Term Disability Insurance
Group Life Insurance

Flexible Spending Account Elections and Claim Details

Amounts contributed for FSA reimbursement are segregated for recordkeeping and accounting purposes only, and this process does not constitute a separate fund as the reimbursements are made from the general assets of the plan sponsor.

I. Health FSA

(a) The maximum amount of Health FSA contributions that an Employee may elect for a Plan Year is $2,750 (or current IRS Maximum).

Note: The Affordable Care Act ("ACA") imposes a limit on the maximum amount of Employee contributions to a Health FSA for any Plan Year. This maximum is indexed to the Consumer Price Index annually and announced by the IRS. This Plan will adopt the maximum amount for the current Plan Year and any subsequent Plan Year(s) unless otherwise elected and communicated to eligible Employees by an updated version of this SPD.

(b) The minimum annual contribution for Health FSA participation is $0.

(c) **Limited Scope Option:** Employees may elect to limit the scope of reimbursement under the Health FSA to dental and vision expenses only, as further described in this SPD, so that the Employee or a Spouse may participate in a Health Savings Account.

(d) **Spousal and/or Children Exclusion:** Employees may elect to exclude the Spouse and/or Dependent(s) from coverage under the Health FSA, as set forth in the SPD, so that the Spouse or Dependents may participate in a Health Savings Account.

(e) **Claims Submission Deadlines**

a. **The Active Employee Claim Runout Period** (the "Claim Runout Period") is the period of 90 days that begins the day after the Plan Year ends, during which the Employee can submit claims for payment of Qualified Expenses incurred during the Plan Year.

COVID-19 Relief: For the period beginning March 1, 2020 and ending 60 days after the announced end of the COVID-19 national emergency, the 90-day Active Employee Claim Runout Period is disregarded. This deadline is suspended, providing additional time to file claims incurred during the Plan Year or extended claims incurred period.

b. **The Terminated Employee Claim Runout Period** is the period of 90 days that begins after an Employee terminates employment (or loses eligibility to participate in the Plan) during which the Employee can submit claims for expenses incurred while the employee remained a Participant.

COVID-19 Relief: For the period beginning March 1, 2020 and ending 60 days after the announced end of the COVID-19 national emergency, the 90-day Terminated Employee Claim Runout Period is disregarded. This deadline is suspended, providing additional time to file claims incurred while the Employee remained a Participant during the Plan Year or extended claims incurred period, when applicable.

(f) **Grace Period for Health FSA Claims**

The Employer has not adopted the IRS-authorized grace period applicable to the Health FSA.

(g) **Carryover for Unused Health FSA Amounts**

The Employer has adopted the IRS-authorized carryover applicable to the Health FSA. If adopted by the Employer, carryover will allow unused FSA amounts in any Plan Year to carry forward and be used to reimburse expenses incurred during the following Plan Year. The maximum amount of carryover permitted is indexed to maximum amount of Health FSA contributions set annually by the IRS. For Plan Years beginning in 2019, $500 is the maximum cumulative carryover amount. For Plan Years beginning in 2020, $550 is the maximum amount. Future carryover maximums will be calculated as 20% of the IRS annual maximum for Health FSA.

In order for you to take advantage of the carryover for any Plan Year, you must be: (1) a Participant in the Health FSA on the last day of the Plan Year from which funds will carryover, and (2) a Participant in the Health FSA on the first day of the Plan Year to which funds will carryover.

The following terms apply to the carryover:

Any funds eligible for carryover can only be used to reimburse Eligible Medical Expenses incurred during the following Plan Year. They are not cashable and cannot be used for any of the other Benefit Options offered under the Plan. The carryover does not affect your Health FSA maximum contribution for the following Plan Year.

The carryover also does not affect the Claim Runout Period. Any unused amounts from the previous Plan Year will be used to reimburse eligible expenses from the previous Plan Year during the 90-day Claim Runout Period. Expenses incurred during the previous Plan Year must be submitted before the end of the Claim Runout Period. Any unused amounts from the end of a Plan Year that exceed $500 and are not used to reimburse expenses incurred during the previous Plan Year will be forfeited at the end of the Claim Runout Period.

> *Example*: Assume the Plan Year is a calendar year with an annual Claim Runout Period from January 1 through March 31. Further assume that you have $800 of unused amounts at the end of Plan Year #1 and you elect a salary reduction amount of $2,500 for Plan Year #2. On February 1 of Plan Year #2, you submit claims and are reimbursed for $350 of expenses incurred during Plan Year #1, leaving $450 of unused carryover amounts that can be used to reimburse expenses incurred during the remainder of Plan Year #2 in addition to your Plan Year #2 election.

Eligible expenses incurred during the following Plan Year and approved for reimbursement will be paid first from available amounts from the following Plan Year contribution (the "ordering rule"). Because claims may be submitted during the Claim Runout Period that extends beyond the end of the Plan Year, unused carryover amounts will reimburse expenses incurred during the following Plan Year once the new election for the following Plan Year is exhausted in order to maximize the FSA amounts of Participants.

> *Example*: The Plan Year is a calendar year with an annual Claim Runout Period from January 1 through March 31. You have $800 of unused amounts at the end of Plan Year #1 and you elect a salary reduction amount of $2,500 for Plan Year #2. On January 15 of Plan Year #2, you submit claims and are reimbursed with respect to $2,800 of expenses incurred during Plan Year #2. The first $2,500 will be reimbursed with Plan Year #2 funds, and the last $300 reimbursed with Plan Year #1 funds. This would leave $300 of unused carryover amounts that can be used to reimburse expenses incurred during Plan Year #1 if submitted during the Claim Runout Period or expenses incurred during Plan Year #2.

II. Dependent Care Assistance Plan ("Dependent Care FSA")

(a) The maximum reimbursement that a Participant may receive during the year is the annual reimbursement amount elected by the Participant on the Salary Reduction Agreement, not to exceed the Plan maximum in (b) below or the IRS maximum provided in Code Section 129.

(b) The maximum annual reimbursement amount for the Dependent Care FSA is as follows: $5,000 for married filing jointly or single and $2,500 for married filing separately.

(c) The minimum contribution for Dependent Care FSA participation is $0.

(d) **Claims Submission Deadlines**

a. **The Active Employee Claim Runout Period** (the "Claims Runout Period") is the period of 90 days that begins the day after the Plan Year ends, during which the Employee can submit claims for payment of Qualified Expenses incurred during the Plan Year.

   COVID-19 Relief: Due to IRS relief extending the dates that Dependent Care FSA claim may be incurred to December 31, 2020, the Active Employee Claims Runout Period for Plan Years ending in 2020 is also extended to December 31, 2020.

b. **The Terminated Employee Claim Runout Period** is the period of 90 days that begins after an Employee terminates employment (or loses eligibility to participate in the Plan) during which the Employee can submit claims for expenses incurred.

c. **Spenddown.** Where applicable, Employees terminating with positive Dependent Care FSA balances may continue to submit claims during the Terminated Employee Claim Runout Period for expenses incurred during the Plan Year or during the Terminated Employee Claim Runout Period.

Authority of Plan Documents

The actual terms and conditions of the individual pre-tax Benefit Options offered under this Plan are contained in separate documents governing each respective benefit. In the event of a substantive conflict between the SPD governing the specific benefit and this document, the SPD governing the specific benefit will control. To that end, each such separate document in its current form is incorporated by reference as if fully recited herein.

Important: This SPD is intended to summarize the benefits under the Plan. Contact the Plan Administrator if you need additional information on any issue related to the Plan.

APPENDIX I
CLAIMS REVIEW PROCEDURE

The Plan has established the following claims review procedures in the event you are denied a benefit under this Plan. The procedure set forth below does not apply to benefit claims filed under the Benefit Options other than the Health FSA and Dependent Care FSA.

COVID-19 Relief (applicable to Health FSA claims review): For the period March 1, 2020 and ending 60 days after the announced end of the COVID-19 national emergency, the deadlines for appealing Health FSA claim denials are disregarded. The deadlines described below are suspended giving additional time to file an Appeal.

Step 1: *Notice is received from Plan Service Provider.* If your claim is denied, you will receive written notice from the Plan Service Provider 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 Plan Service Provider, the Plan Service Provider 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 Plan Service Provider 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 Plan Service Provider, 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 Plan Service Provider 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 Plan Service Provider.* 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 Plan Service Provider.
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 Plan Service Provider.
Step 6: *If you still disagree with the Plan Service Provider's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Plan Service Provider'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 Plan Service Provider. 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.

Important Information

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.