CAFETERIA PLAN

PREMIUM REDUCTION OPTION *PLUS*

FLEXIBLE SPENDING ACCOUNTS

SUMMARY PLAN DESCRIPTION

AS ADOPTED BY
DATA ELECTRONIC DEVICES, INC.

TABLE OF CONTENTS

PART 1. INTRODUCTION **3**

PART 2. GENERAL INFORMATION ABOUT THE PLAN **3**

Q-1 What is the purpose of the Plan? 3
Q-2 What benefits are offered through the Plan? 3
Q-3 Who can participate in the Plan? 3
Q-4 What happens if I terminate employment (or cease to be eligible) and then am rehired (become eligible again) during the same Plan Year? 3
Q-5 What happens if I take a leave of absence? 4
Q-6 What tax advantages can I gain by participating in the Plan? 4
Q-7 How do I become a Participant? 5
Q-8 What are the enrollment periods? 5
Q-9 How long is my election to participate (or not to participate) effective? 6
Q-10 What happens if I fail to return my Benefit Election Form? 6
Q-11 Can I change my election during the Plan Year? 6
Q-12 How are my Benefit Package Options that I elect paid for under this Plan? 9
Q-13 What happens if a claim for benefits under the Plan is denied? 9
Q-14 What effect will Plan participation have on Social Security and other benefits? 10

PART 3. CASH BENEFITS **10**

PART 4. HEALTH CARE PREMIUM REIMBURSEMENT **10**

Q-1 Who can elect Health Care Premium Reimbursement (HCPR)? 10
Q-2 What are Health Care Premium Expenses? 10
Q-3 How do I become a Participant? 10
Q-4 What happens if I fail to return my Benefit Election Form? 10
Q-5 How do I receive Reimbursement under a Health Care Premium Reimbursement Program? 11
Q-6 Can I change the election during the year? 11
Q-7 What happens if I have salary reduced more than my actual Health Care Premium Expenses at the end of the Plan Year? 11

PART 5. HEALTH FSA BENEFITS **11**

Q-1 Who can participate in the Health FSA? 11
Q-2 How do I become a Participant? 11
Q-3 When does coverage under the Health FSA end? 12
Q-4 What happens if I take a leave of absence? 12
Q-5 What happens if I fail to return my Benefit Election Form? 12
Q-6 How is my annual election amount credited to my Health FSA? 12
Q-7 What annual benefits are available under the Health FSA, and how much will they cost? 12
Q-8 How do I submit a claim for reimbursement under the Health FSA? 12
Q-9 What is an "Eligible Medical Expense"? 13
Q-10 How do I receive my payment under the Health FSA? 14
Q-11 Who is an "eligible dependent" for which I can claim expenses for reimbursement? 14
Q-12 When must a reimbursable expense be incurred? 14
Q-13 Can I change the election during the year? 14
Q-14 What happens if I still have a balance in my Account at the end of the Plan Year? 14
Q-15 Can I continue coverage in my Account? 14
Q-16 What happens if a claim for benefits under the Health FSA is denied? 16
Q-17 Will my health information be kept confidential? 17

PART 6. DEPENDENT CARE ASSISTANCE PLAN 17

Q-1 Who can participate in a DCAP? 17
Q-2 How do I become a Participant? 17
Q-3 When does coverage under the DCAP end? 17
Q-4 What happens if I take a leave of absence? 17
Q-5 What happens if I fail to return my Benefit Election form? 17
Q-6 How is my annual election amount credited to my DCAP Account? 18
Q-7 Are there any other limits on what DCAP benefits are tax free? 18
Q-8 Is there any other way I can save taxes on my DCAP expenses? 18
Q-9 What is the Household and Dependent Care Credit? 18
Q-10 If I participate in the DCAP, can I claim the Household and Dependent Care Credit on my federal income tax return? 18
Q-11 Under what circumstances can I receive reimbursement under the DCAP"? 18
Q-12 How do I submit a claim for reimbursement under the DCAP? 19
Q-13 Will I be taxed on the DCAP benefits I receive? 20
Q-14 Can I change my election if I change day care providers during the year and the rates are different? 20
Q-15 Can I change my election if a relative starts keeping my children for free? 20
Q-16 What happens if I still have a balance in my DCAP Account at the end of the Plan Year? 20
Q-17 What happens if my claim for DCAP benefits is denied? 20
Q-18 How do I receive my payment under the DCAP? 21

PART 7. ERISA RIGHTS 21

PART 8. *BENEFIT CARD* 22

PART 9. PLAN INFORMATION SUMMARY 24

1. Employer Organization 24
2. Plan Elections 24
3. Eligibility Requirements 24
4. Plan Entry Date 24
5. Benefit Package Options 25
6. Flexible Spending Account Elections 25
7. *Benefit Card* 26
8. Incorporated By Reference 26

Section 125 Cafeteria Plan

Part 1. Introduction

Your employer ("Employer") is pleased to sponsor an employee benefit program known as a Cafeteria Plan ("Plan") for certain Eligible Employees of the Employer. It is called a Cafeteria Plan because you can choose from a selection of different insurance and fringe benefit programs according to your needs. Your Employer gives you this opportunity to use a salary conversion arrangement through which you can use pre-tax dollars to pay for your benefits instead of paying for the benefits through after-tax payroll deductions. By paying for the benefits with pre-tax dollars, you save money by not having to pay Social Security and income taxes on your salary reduction. However, you may still have the option of paying for your benefits with after-tax dollars.

This Summary Plan Description ("SPD") describes the basic features of the Plan; how it operates, and how you can get the maximum advantage from it. The Plan is established pursuant to a plan document into which this SPD is incorporated (i.e. the plan document and this SPD constitute the plan document). However, if a conflict exists between the plan document and this SPD, the plan document will take precedence.

Part 2. General Information about the Plan

Q-1 What is the purpose of the Plan?

This Plan is designed to allow Eligible Employees to choose one or more of the benefits offered through the Plan and, using funds provided through employee salary reduction, to pay for the selected benefits with pre-tax dollars. It is established for the exclusive benefit of Participants.

Q-2 What benefits are offered through the Plan?

The Plan allows you to make your share of the contributions with Pre-tax contributions for qualified benefits ("Benefit Package Options") offered under the Plan to the extent such benefits are listed in Part 8 below. Benefit Package Options offered under the Plan may include but are not limited to group benefits accident and health benefits sponsored by your employer, individual accident and health insurance policies issued to employees (to the extent approved by the Employer), a Health and/or Dependent Care FSA, and/or a Code Section 223 Health Savings Account.

You will receive information materials before each enrollment period explaining the various benefit options your Employer is offering for the next Plan Year.

Q-3 Who can participate in the Plan?

Any employee (as that term is defined in the Plan Document) of the Employer who satisfies the Eligibility Requirements established by the Employer in the Plan Information Summary (as summarized in Part 9 below), is eligible to participate in this Plan.

You will cease to be a Participant if:

(a) the Plan terminates,

(b) you cease to be eligible for the Plan (e.g. the Participant's employment is terminated),

(c) you revoke your election to participate, or

(d) the Plan is amended to exclude you or the class of employees of which you are a member.

You may be entitled to temporarily continue coverage under one or more of the Benefit Package Options that provide group health coverage. Refer to the applicable plan summaries for more information on COBRA continuation coverage.

Q-4 What happens if I terminate employment (or cease to be eligible) and then am rehired (become eligible again) during the same Plan Year?

If you terminate your employment or you cease to be eligible for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then you are rehired or again become eligible within 30 days or less of the date of a termination of employment or cessation of eligibility, then you will be reinstated in the Plan (assuming you otherwise satisfy the eligibility requirements of the Plan) with the same elections you had before termination (subject to any restrictions imposed under the applicable Benefit Package Options). If you are rehired or again become eligible more

than 30 days following termination of employment or cessation of eligibility and you are otherwise eligible to participate in the Plan, then you may make new elections.

Q-5 What happens if I take a leave of absence?

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your group health coverage on the same terms and conditions as though you were still active (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 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 with after-tax dollars while on leave, or you may be given the option to 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 compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). 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. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

(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 upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Package 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 Employer may, on a uniform and consistent basis, 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 your Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Package Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Package 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 Package 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 Package Option, the election change rules in Part 2 Q-11 below will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-6 What tax advantages can I gain by participating in the Plan?

By participating in the Plan, you will not have to pay income tax or Social Security tax on your elections. Following is an illustration of how a hypothetical employee saved on taxes by participating in a cafeteria plan. Let's assume our hypothetical employee makes $2,500 each month and has 28% withheld for federal withholding and 7.65% for Social Security. The employee's take-home pay before participating in the Plan is $1,609 a month. Out of that, $348 a month is paid for insurance benefits, $100 for Health FSA, and $200 for Dependent Care FSA. The employee decides to participate in the cafeteria plan. By participating in the Plan and paying contributions on a pre-tax basis under the Plan, the employee saved $230 a month. Following is a table to better illustrate the example.

Breakdown of Pay Check and Deductions	Not Participating in Cafeteria Plan	Participating in Cafeteria Plan
Gross Monthly Pay	**$2,500.00**	**$2,500.00**
Less Premium for Major Medical		(348.00)
Less Medical/Dental Expenses		(100.00)
Less Day Care Expenses		(200.00)
Taxable Income	2,500.00	1,852.00
Less 28% Federal Withholding	(700.00)	(519.00)
Less 7.65% Social Security Tax	(191.00)	(142.00)
Less Premium for Major Medical	(348.00)	
Less Health FSA Expenses	(100.00)	
Less Day Care Expenses	(200.00)	
Spendable Income	**$961.00**	**$1,191.00**

The employee saved $230 a month or $2,760 a year by participating in Plan!

This savings result in extra disposable income and this occurs because the employee participated in the Plan and made the required employee contributions before the taxes were withheld. This is just one example of the possible tax savings under the Plan.

Q-7 How do I become a Participant?

You become a Participant in the Cafeteria Plan by completing and submitting a Benefit Election Form (or Salary Reduction Agreement) to the Plan Administrator (or its designee identified on the election form) during one of the applicable enrollment periods described in Q-8 below. Your effective date of participation in the Cafeteria Plan is also described in Q-8 below. Enrollment in the Cafeteria Plan does not necessarily result in enrollment in the Benefit Package Options. Coverage under the Benefit Package Options that you elect will begin only as set forth in the summary plan descriptions or other written material for each Benefit Package Option that you elect.

Q-8 What are the enrollment periods?

There are three enrollment periods:

1. Enrollment Period prior to the Effective Date. This is the enrollment period that occurs before the Plan's Effective Date (as described in the Adoption Agreement). An Election made during this Enrollment Period is effective on the Effective Date of the Plan.
2. Initial Enrollment Period. The Initial Enrollment Period is the period during which newly Eligible Employees enroll in the Plan. The Initial Enrollment Period is described in the enrollment material provided by the Plan Administrator. An election to participate that is made during this enrollment period will be effective on the Plan Entry Date.
3. Annual Enrollment Period. The Annual Enrollment Period is the period each year in which participants may elect to change and/or continue their elections or Eligible Employees may elect to participate for the next Plan Year. The Annual Enrollment Period is described in your enrollment material that you will receive prior to the Annual Enrollment Period. An election to participate made during this period will be effective on the anniversary date.

If you have the ability to enroll by phone or Internet, separate enrollment periods may be established for paper, telephone, and Internet. Your Employer will tell you what enrollment periods are established for each.

See Q-10 below for what happens when you fail to return a Benefit Election Form during the enrollment period.

Q-9 How long is my election to participate (or not to participate) effective?

Your elections (either to participate or not) are for the entire Plan Year, which is usually 12 months. The first Plan Year and the last Plan Year may be for a shorter period. See Part 8 below for the exact dates of your Plan Year.

Q-10 What happens if I fail to return my Benefit Election Form?

If you are not currently participating in the Plan and you fail to return a Benefit Election Form before the end of the applicable Enrollment Period, it will be assumed that you have elected to receive your full compensation in cash and you cannot elect to become a Participant until the next Annual Enrollment Period or following the date you experience a change in status that allows you to enroll mid Plan Year (assuming you timely change your election). If you are currently participating in the Plan and fail to submit a Benefit Election Form by the end of the Annual Enrollment Period for the next Plan Year, your elections for the next Plan Year will depend on which benefits you currently have.

If you have currently elected to pay for one of your Benefit Package Options (other than Health FSA, Code Section 223 Health Savings Account (HSA), Health Premium Reimbursement Account, and/or Dependent Care FSA) with pre-tax contributions, it will be assumed that you want to continue these elections for the next Plan Year (and contribute your share of the cost on a pre-tax basis, adjusted to reflect any increase in the contribution). Otherwise, your election under the Plan will terminate at the end of the Plan Year.

Q-11 Can I change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the benefits you have selected during the Plan Year, although your election will automatically terminate if you are no longer working for the Employer or you are no longer eligible. You may change your elections only during the Annual Enrollment Period, and then the change will not be effective until the beginning of the next Plan Year.

There are several important exceptions to this general rule. You may change or revoke your previous elections during the Plan Year if you experience one of the events listed below.

> **Please refer to the Change of Status Matrix (distributed with this SPD) for a table of the qualifying events, the benefits affected by each event, and the possible changes in elections that may take place for each benefit. If you have a qualifying event, you must submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to enroll.**

Note: These rules do not apply to a Code Section 223 Health Savings Account offered under the Cafeteria Plan. See Part 7 below for more information regarding election changes related to the Health Savings Account.

1. **Changes in Status**. If one or more of the following Changes in Status occur, you may revoke your old 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 cafeteria 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 specific requirements in order to alter your election based on that Change in Status:

- *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 cafeteria 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 for himself, his wife Sharon, and their child. 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 tax 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 cafeteria 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 cafeteria 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 cafeteria 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 (such as 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. Please refer to the group health plan description for an explanation of special enrollment rights.

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 underlying 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 either (a) to make an increase in your contributions, (b) revoke your election and receive coverage under another Benefit Package 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 Package Options, however, 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 does not apply to Health FSA benefits.

Example: Employee Mike is covered under an indemnity option of his employer's accident and 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 Package Option, which provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, 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 newly added or significantly improved option, so long as the newly added 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 does not apply to Health FSA benefits.

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 may modify your election(s) downward 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 federal income tax law**.**

Q-12 How are my Benefit Package Options that I elect paid for under this Plan?

You may be *required* to pay for any Benefit Package Option coverage that you elect with Pre-tax Contributions. Alternatively, the Employer may allow you to pay your share of the contributions with after-tax contributions. The enrollment material you receive will indicate whether you have to pay with Pre-Tax Contributions or whether you have an option to choose to pay with after-tax contributions.

When you elect to participate in this Cafeteria Plan, an amount equal to your share of the annual cost of those Benefit Package 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 (or it is a plan requirement), 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 Package Options you choose with Benefit Credits. The amount of Benefit Credits that is applied by the Employer towards the cost of the Benefit Plan 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. The Benefit Credits 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 Benefit Credit be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material.

The Employer may provide you with employer contributions over which you have discretion to choose how to apply to the various Benefit Package Options available under the Cafeteria Plan. The Benefit Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment material.

Q-13 What happens if a claim for benefits under the Plan is denied?

If you are denied a benefit under this Plan (e.g. election changes, eligibility for pre-tax benefits), you should proceed in accordance with the following claims review procedures. If you are denied a benefit under one of the Benefit Package Options, you should proceed in accordance with the claims review procedures established for that particular Benefit Package Option, if any.

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. 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.

Step 2: Review your notice carefully. Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- 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;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures;
- A right to request all documentation relevant to your claim.

Step 3: If you disagree with the decision, you may file an appeal. If you do not agree with the decision, and you wish to appeal, you must file a written appeal in accordance with the Notice referenced in Step 1 no later than 180 days of receipt of that Notice. 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 following appeal. If the claim is again denied, you will be notified in writing. If there is only one level of appeal, notice of the denial will be sent no later than 60 days after the appeal is received. See below for more information if the Plan has established two levels of appeal.

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.

Step 6 (if there is a second level of appeal as indicated in the notice of denial referenced in Step One and/or Four above): If you still disagree with the decision, and you wish to appeal, you must file a second level appeal with the Plan Administrator within the time allotted for appealing as set forth in the notice of denial from the Plan Service Provider (referenced in Step 4). 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 will support your claim.

If the Plan Administrator denies your second 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 2 above.

Q-14 What effect will Plan participation have on Social Security and other benefits?

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

Part 3. Cash Benefits

During any one Plan Year, the Maximum Contribution Amount total a Participant can elect cannot exceed the sum of the maximum contributions for Benefit Package Options offered under Part 8 below. Any part of this annual benefit limit you do not apply toward tax-free benefits (or the remainder of your annual pay if less than the unused portion of the Maximum Contribution Amount) 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 Package Options made available under the Plan will revert back to the employer.

Part 4. Health Care Premium Reimbursement

If listed as a benefit offered under the Plan in Part 8 below, you can elect to allocate pre-tax contributions for reimbursement of Health Care Premium Reimbursement (HCPR).

Q-1 Who can elect Health Care Premium Reimbursement (HCPR)?

If you are eligible to be a participant in the Cafeteria Plan, you can elect to make pre-tax contributions for certain employer approved individual insurance policies. If you do make a proper election, amounts equal to Health Care Premium Expenses that you incur or pay will be withheld from your pay and you will be reimbursed (either directly or indirectly) for such expenses with these amounts.

Q-2 What are Health Care Premium Expenses?

Health Care Premium Expenses are the premiums that you pay for an individual insurance policy(ies) that you purchase outside of any employer plan. Such expenses must meet the following conditions: (a) the individual insurance policy must be determined by the Plan Administrator to be a "Qualified Benefit" before the beginning of the Plan Year or, if you are a new hire, before the effective date of your participation in the Plan. For purposes of the HCPR, a Qualified Benefit is an individual insurance policy that provides accident and health insurance described in Code Section 106, (b) the contract must be an individually purchased contract and not an employer- sponsored insurance plan; and (c) you must be the policyholder of the insurance policy.

Q-3 How do I become a Participant?

During the applicable Enrollment Periods described in Part 2, Q-8 you must submit a Benefit Election Form wherein you elect the amount you want withheld for reimbursement of Health Care Premium Expenses. In addition, you must (a) provide the Plan Administrator with a copy of the individual accident or health insurance policy that you have purchased for yourself outside of any employer plan and (b) indicate on the Benefit Election Form the premium amount that you will expect to pay during the Plan Year for such policy. The Plan Administrator will notify you if the insurance policy is determined to be a "Qualified Benefit" under the Plan. See Part 8 below for your effective date of participation. The effective date of coverage may vary by Enrollment Period.

If you elect Health Care Premium Expense Reimbursement (HCPR), a record will be kept of all salary reductions made for reimbursement of Health Care Premium Expenses as well as all actual reimbursements.

Q-4 What happens if I fail to return my Benefit Election Form?

If you fail to return a Benefit Election Form electing Health Care Premium Reimbursement (whether you are currently participating or not) before the end of the applicable Enrollment Period, it will be assumed that you have elected to forgo Health Care Premium Reimbursement (HCPR). See Part 2.Q-10 above for further discussion.

Q-5 How do I receive Reimbursement under a Health Care Premium Reimbursement Program?

If you elect to participate in the HCPR, you will have to take certain steps to be reimbursed for your eligible premiums. You will be supplied with the necessary claim forms. In addition to the claim form, you must submit to the Plan Administrator a statement from the insurance carrier indicating that you have paid the Eligible Health Care Premium Expenses for which you are requesting reimbursement unless the Employer is paying the carrier directly. In that case, you must submit a statement or invoice from the carrier indicating the amount of the premium and the period of coverage. If the Employer is paying the carrier directly, the insurance carrier will be paid the premium (up to the amount of pre-tax contributions you have set aside for that period) in the next check processing cycle. Your Plan Administrator will advise you how often the checks are processed. The Employer, the Plan, the Plan Administrator, and the Plan Service Provider are not responsible for any coverage that you lose for failure to pay a premium if your salary reduction election for Health Care Premium Expenses is insufficient to cover the premium amount.

The amount of your salary reduction for such benefits cannot exceed the amount your are required to pay for such coverage. The amount of your reimbursement cannot exceed the amount that you have reduced from your salary to date, reduced by prior reimbursements. If the amount that you have salary reduced to date is equal to or less than your claim, your claim for eligible expenses will be reimbursed in full. If the amount that you have salary reduced is less than your claim amount, the excess part of the claim will be carried over into the following pay cycles to be paid as your balance can cover it (assuming you are still eligible). In other words, as additional salary conversion amounts are made, a reimbursement check will be processed automatically for any unpaid portions of any previously submitted claims (to the extent such claims are eligible for reimbursement). Remember, no expenses can be reimbursed that exceeds the salary reduction you have made up to that date reduced by any previous reimbursements. You cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Benefit Election Form becomes effective, or after the Claim Submission Grace Period or Closing Period, whichever is applicable. Also, no check will be written if the current amount payable is less than the Minimum Check Amount as specified in Part 9 below. The Minimum Check Amount will not apply for processing the final checks during any Plan Year.

At the end of the Plan Year, you will have a closing period (as stated in Part 5, Q-8) to turn in claims for premiums incurred during the Plan Year. No claims can be submitted for reimbursement after that time. Your Employer may set a different claims submission grace period for terminated employees; if so, you will find this information in Part 5, Q-8.

Q-6 Can I change the election during the year?

You can change elections during the year only if you experience one of the qualifying events listed in Part 2, Q-11 and follow the procedures outlined within that question.

Q-7 What happens if I have salary reduced more than my actual Health Care Premium Expenses at the end of the Plan Year?

The cafeteria plan rules prohibit the return of any salary reductions that are not used for Health Care Premium Expenses before the end of the Closing or Claims Submission Grace Period (whichever is applicable).

The Employer will use the forfeitures to offset administration expenses. Also, any uncashed reimbursement checks will be forfeited if not cashed within 90 days of issue.

Part 5. Health FSA Benefits

Participation in the Medical Reimbursement Plan (Health FSA), if listed as a benefit offered under the Plan (see Part 8 below), allows you to purchase a specific level of Health FSA benefits, paying for coverage with pre-tax dollars elected on the Benefit Election Form in lieu of a corresponding amount of current pay. This arrangement helps you because the level of coverage you elect is nontaxable, and you save Social Security and income taxes on the amount of premiums you pay.

Q-1 Who can participate in the Health FSA?

If you are eligible to be a participant in the Cafeteria Plan, you are eligible to participate in the Health FSA.

Q-2 How do I become a Participant?

You can participate by electing the Health FSA during the applicable Enrollment Periods described in Part 2, Q-8 to determine when your participation will begin. Effective date of participation will vary by Enrollment Period. Once you elect benefits under a Health FSA, a Health Care Account will be set up in your name to record your benefits and the contributions you make for such benefits during the Plan Year. No actual account is established to hold funds; it is merely a bookkeeping account.

As discussed in Part 5, Q-9 below, you may have the option to elect to participate in a traditional Health FSA or an FSA limited to vision, dental, and preventive care benefits (a "Limited Health FSA").

Once you become a participant, you may receive reimbursements for Eligible Medical Expenses incurred by you and your Eligible Dependents (see Part 5, Q-11 below for more information on Eligible Dependents) unless you elect otherwise.

Q-3 When does coverage under the Health FSA end?

Participation in the Health FSA continues until (i) you elect not to participate; (ii) the end of the Plan Year unless you make an election during the annual election period (iii) you no longer satisfy the eligibility requirements described in Part 9 below; (iv) you terminate employment with the employer; or (v) the Plan is terminated or it is amended to exclude you or the class of employees of which you are a member. You may be entitled to temporarily continue your coverage under the Health FSA once your coverage ends for certain reasons. See Q-15 below for more information.

Q-4 What happens if I take a leave of absence?

Generally, the rules described in Part 2 Q-5 above apply. However, if your Health FSA coverage ceases during your FMLA leave, you will be entitled to elect whether to be reinstated in the Health FSA, at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at Health FSA 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-5 What happens if I fail to return my Benefit Election Form?

If you are not currently participating in the Plan and fail to return a Benefit Election Form before the end of the enrollment period, it will be assumed that you have elected to receive your full compensation in cash and you cannot elect to participate until the next Annual Enrollment Period or you experience a change in status event that permits you to enroll in the Plan during the Plan Year.

If you have currently elected to participate in a Health FSA, it will be assumed that you do not want to continue participation in the Health FSA and the deductions will cease as of the first day of the next Plan Year (unless you elect to stop participating before then).

See Part 2, Q-10 for further discussion.

Q-6 How is my annual election amount credited to my Health FSA?

After you submit a Benefit Election Form specifying the amount you want deducted each pay period, that amount will be deducted from your pay before applicable federal and state taxes and credited to your Health Care Account each pay period. This money will be available for reimbursement of eligible medical expenses. The available amount in your Health Care Account at any particular time will be the total amount elected for the Plan Year under your Health FSA less any reimbursements you may have already received. For example, if you have elected an annual salary conversion of $2,400 for eligible Health FSA benefits, then $2,400 would be credited to your Health Care Account during the Plan Year. If you are paid semi-monthly, $100 a payday (or $200 a month) will be credited to the Health FSA Account to pay for these expenses, but your reimbursements will not depend on the amount you have contributed. You can file for all or part of this $2,400 reimbursement at any time during the Plan Year (reduced by reimbursement for expenses incurred during that Plan Year).

Q-7 What annual benefits are available under the Health FSA, and how much will they cost?

You can choose any amount of annual benefits you desire within the limits set forth in Part 8 below. You will be required to make annual contributions corresponding to your chosen benefit level.

Q-8 How do I submit a claim for reimbursement under the Health FSA?

Under this Health FSA, you have the method(s) of reimbursement detailed below.

You can complete and submit a written claim for reimbursement ("Traditional Paper Claims"). When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. 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:

a) The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over the counter drug, the written statement must indicate the name of the drug;
b) The date the expense was incurred; and

c) The amount of the expense.

You must also certify that you have not been reimbursed for the expense and that you will not seek reimbursement for it from any other source. You may be required to provide additional documentation if the Plan Administrator (or its designee) determines that additional information is needed to adjudicate the claim. 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 Closing Period. The Closing Period is described in the Plan Information Summary.

You may have a claim submitted by means of a provider supplied electronic claim file ("Import"). 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.

Alternatively, you may be able to use, if enabled as a Plan option in Part 8, the *Benefit Card* to pay the expense. In order to be eligible for the *Benefit Card*, you must agree to abide by the terms and conditions of the *Benefit Card* Program (the "Program") as set forth in Part 9 and in the *Benefit Card* Cardholder Agreement (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.

Q-9 What is an "Eligible Medical Expense"?

a. General Rule: 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);

You certify that 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 and over the counter drugs (and over the counter products & devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Service Provider/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

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

Health insurance premiums; and

Expenses incurred for qualified long term care services.

Any other expenses that are specifically excluded by the Employer per a list attached and incorporated into the SPD by the Employer

b. *If you currently maintain or wish to establish a personal Health Savings Account:* According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), you will not be able to make/receive tax favored contributions to your Health Savings Account if you participate in a Health FSA that reimburses general medical expenses as defined in "a" above. You may, however, be eligible to make/receive tax favored contributions to a personal Health Savings Account and participate in a Health FSA if the Health FSA reimbursement is limited in scope to the following unreimbursed Code Section 213(d) expenses (determined in the sole discretion of the Plan Administrator):

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

Preventive care is defined in accordance with applicable rules and regulations. This may include any prescription or over the counter drugs to the extent such drugs are taken by an eligible individual (i) to delay or prevent the onset of

symptoms of a condition for which symptoms have not yet manifested themselves (i.e. the eligible individual is a symptomatic) (ii) to prevent the recurrence of a condition from which the eligible individual has recovered or (iii) as part of a preventive care treatment program (e.g. a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition. Whether a service or treatment constitutes "preventive care" is subject to the sole discretion of the Plan Administrator.

You may make such an election to limit the scope of reimbursement during the Initial Enrollment Period or during the Annual Enrollment Period described in Part 2 above.

Q-10 How do I receive my payment under the 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 (this check may be written off a Plan Service Provider account; however, 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); (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-11 Who is an "eligible dependent" for which I can claim expenses for reimbursement?

You can claim reimbursement for eligible medical expenses incurred by your legal spouse (as determined in accordance with state law to the extent consistent with the federal Defense of Marriage Act), and any individual who would qualify as a dependent under Code Section 105(b), and any child for whom you are required to provide health coverage pursuant to a Qualified Medical Support Order (coverage for a child required to be covered as a result of a QMCSO may be taxable). Also, children of divorced parents are considered to be a dependent of both parents to the extent that both parents together provide over half of the child's support and the child resides with one of the parents.

If your spouse maintains a Code Section 223 health savings account or wishes to establish a Code Section 223 health savings account, your participation in this Health FSA (to the extent reimbursement under this Health FSA is not restricted as described in Q-9(b) above) may cause your spouse to be ineligible for a Code Section 223 health savings account if your spouse and/or your "dependents" are covered under this Health FSA. In that case, you may make a prospective election at any time to exclude your dependents from coverage and cover only yourself under this Health FSA. You may make such an election to limit the scope of eligible dependents during the Initial Enrollment Period or during the Annual Enrollment Period described in Part 2 above.

Q-12 When must a reimbursable expense be incurred?

Eligible expenses reimbursed under the Plan must be incurred during the Participant's period of coverage under the Plan. Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for the services or pays for the medical care. During your current participation year, you cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Salary Reduction and Election Form becomes effective, expenses incurred after the date that you stop being eligible under this Health FSA (except as described in Part 5, Q-15 below) or for any expense incurred after the close of the Plan Year.

Q-13 Can I change the election during the year?

Only if you experience one of the qualifying events listed in Part 2, Q-11 and follow the procedures outlined within that section.

Q-14 What happens if I still have a balance in my Account at the end of the Plan Year?

Any unused amounts left in your Account at the end of the Plan Year will be forfeited and returned to your employer to offset administrative expenses and future costs. Also, any uncashed reimbursement checks will be forfeited if not cashed within 90 days of issue.

Q-15 Can I continue coverage in my Account?

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 (called "continuation coverage" or COBRA) at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the Health FSA, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

If you are a participant in the Health FSA, then you have a right to choose continuation coverage under the Health FSA if you lose your coverage because of:

- a reduction in your hours of employment;
- a voluntary or involuntary termination of your employment (for reasons other than gross misconduct), or
- a military leave of absence (in accordance with USERRA).

If you are the spouse of a Participant, then you have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- The death of your spouse;
- A voluntary or involuntary termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- The divorce or legal separation from your spouse.

In the case of a Dependent child of a participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- The death of the employee;
- A voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
- His or her parents' divorce or legal separation; or
- He or she ceases to be a dependent child.

A child who is born to, or placed for adoption with, the employee during a period of continuation coverage is also entitled to continuation coverage under COBRA provided the child is properly enrolled. Those who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries"

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. You will be eligible to make a change in your benefit election with respect to the Plan 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.

You or your covered dependents (including your spouse) must notify the employer of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost because of the event. When the COBRA Administrator, as identified in the Plan Information Summary, is notified in writing that one of these events has occurred, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage. Notice to an employee's spouse is treated as notice to any covered Dependents who reside with the spouse.

The COBRA Participant and/or covered dependent are responsible for notifying the Plan Administrator if he or she becomes covered under another group health plan.

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan. The covered employee who is a qualified beneficiary may elect coverage for all other qualified beneficiaries; however, the covered employee may not decline coverage for a qualified beneficiary spouse. A parent or guardian may elect coverage for a minor dependent child who is a qualified beneficiary. In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan Administrator. You have 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, to inform the Plan Administrator that you wish to continue coverage. Failure to return the election form within the 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.

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 premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

The maximum period for which coverage may be continued will be until the end of the Plan Year in which the qualifying event occurs. To the extent that Non-elective Employer contributions are provided, the maximum duration of coverage

may be 18 or 36 months from the qualifying event (depending on the type of qualifying event). You will be notified of the duration of continuation coverage when you have a qualifying event. However, continuation coverage may end earlier for any of the following reasons:

- The contribution for your continuation coverage is not paid on time or it is insufficient (Note: If your payment is insufficient by the lesser of 10% of the required COBRA premium, or $50, you will be given 30 days to cure the shortfall);
- The date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation, after you elect continuation coverage;
- The date that you first become entitled to Medicare, after you elect continuation coverage; or
- The date the employer no longer provides group health coverage to any of its employees.

Q-16 What happens if a claim for benefits under the Health FSA is denied?

If you are denied a benefit under the Health FSA, you should proceed in accordance with the following claims review procedures.

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:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- 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;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures;
- 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, you may file a written appeal. You should file your appeal no later than 180 days of receipt of the notice described in Step 1. If the Plan has established only one level of review, you should file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you should file your appeal with the Plan Service Provider. The notice of denial reference in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal. Regardless, 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 claims reviewer. If the claim is again denied, you will be notified in writing. If the plan has established two levels of appeal as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the Plan Service Provider. Otherwise, notice of the denial will be sent no later than 60 days after the appeal is received by the Plan Administrator.

Step 5: Review your notice carefully. You should take the same action that you take 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 there is a second level of appeal as indicated in the notice of denial): 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, you may file a written appeal with the Plan Administrator within the allotted number of days set forth in the notice of denial 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 will 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 2 above.

Important Information

Other important information regarding your appeals:

- 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 determination will not be involved in a subsequent decision);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Q-17 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 health privacy policies of the Plan.

Part 6. Dependent Care Assistance Plan

Another important component of your Employer's Cafeteria Plan is the Dependent Care Assistance Plan. Participation in this Plan allows you to receive income tax-free reimbursement for some or all of your work-related dependent care expenses under a related Dependent Care Assistance Plan (DCAP). A DCAP allows you to provide a source of pre-tax funds to reimburse you for your eligible expenses. You do this by entering into a salary conversion agreement (Benefit Election Form) with the Employer instead of receiving a corresponding amount of your regular pay. This arrangement saves you money; you pay less Social Security and income taxes because the salary conversion paying for your elected benefits is not taxable.

Q-1 Who can participate in a DCAP?

If you are eligible to be a participant in the Cafeteria Plan, you can participate in the DCAP. If you are married, your spouse must also work, go to school full time, or be incapable of self-care for you to be eligible.

Q-2 How do I become a Participant?

You can participate by electing the DCAP Benefit during the applicable Enrollment Periods. See Part 2, Q-8 for your effective date of participation. Effective dates of participation vary by Enrollment Period. Once you elect benefits under this DCAP, a Dependent Care Expense Reimbursement Account (DCAP Account) will be set up in your name to record your benefits and the contributions you make for such benefits during the Plan Year.

Q-3 When does coverage under the DCAP end?

You continue to participate in the Dependent Care FSA until (i) you elect not to participate; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) the end of the Plan Year unless you make an election to participate during the annual election period; (iv) you terminate employment with the employer (there are special rules for terminating employees), or (v) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. However, you may be able to continue to submit claims for reimbursements for Eligible Employment Related Expenses incurred after the date that you terminate employment up to balance in your Dependent Care Account as of the date you terminate employment.

Q-4 What happens if I take a leave of absence?

Generally, the rules described in Part 2 Q-5 above of this SPD apply to the Dependent Care FSA.

Q-5 What happens if I fail to return my Benefit Election form?

If you are not currently participating in the Plan and fail to return a Benefit Election Form before the end of the enrollment period, it will be assumed that you have elected to receive your full compensation in cash and you cannot become a Participant until the next Plan Year. The only exception to this is if you have experienced one of the qualifying events listed in Part 2, Q-11 above. If so, you must submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to enroll.

If you have currently elected to participate in a DCAP and you fail to return the Benefit Election Form, it will be assumed that you do not want to continue participation in the DCAP and the deductions will cease.

See Part 2, Q-10 above for further discussion.

Q-6 How is my annual election amount credited to my DCAP Account?

After you submit a Benefit Election Form specifying the amount you want deducted each pay period, that amount will be deducted from your pay and credited to your DCAP Account each pay period. This money will be available for reimbursement of your dependent care expenses. The available amount in your DCAP Account at any particular time will be the amount credited to your DCAP Account to date less any reimbursements you may have already received.

Q-7 Are there any other limits on what DCAP benefits are tax-free?

In addition to the dollar limitations in Part 8 below, the maximum amount of DCAP benefits you may exclude from income during any calendar year cannot be more than:

- If you are **not** married as of the end of the year, your earned income for the year, or
- If you **are** married at the end of the year, the **lesser** of your earned income for the year, or your spouse's earned income.

Q-8 Is there any other way I can save taxes on my DCAP expenses?

Yes, you can claim the Household and Dependent Care Credit when filing your federal income tax return.

Q-9 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 $1050 for one Qualifying Individual or $2100 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 incomes 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% = $1152, because the entire expense would have been taken into account, not just the first $3,000.

Q-10 If I participate in the DCAP, can I claim the Household and Dependent Care Credit on my federal income tax return?

If you participate in both, each dollar that you receive under the DCAP FSA reduces the amount of expenses that may be taken into consideration under the Household and Dependent Care Credit (that is, the $3,000 and $6,000 amount).

Example: If you had $5,000 in dependent care expenses for 2001 for two children, but only elected $2000 for your DCAP, you would still be eligible for a partial tax credit. You would calculate your tax credit by subtracting $2,000 (amount reimbursed by DCAP) from $6000 (the maximum allowed for the Household and Dependent Care Credit). This would leave you with $4000, your basis for the Household and Dependent Care Credit. You would then apply the formula for the credit as stated in Q-9 above.

Example: If you had $10,000 in dependent care expenses for 2001 and claimed the maximum $5,000 under a DCAP, you cannot claim the other $5,000 as a Household and Dependent Care Credit on your federal income tax return.

Q-11 Under what circumstances can I receive reimbursement under the DCAP"?

You can be reimbursed for work-related dependent care expenses provided all the following conditions are satisfied:

1. The expenses are for services rendered after the date of your Dependent Care election and before the end of the Plan Year.
2. The individual for whom you incurred the expenses is a "Qualifying Individual". A "Qualifying Individual" is a:
   - An individual age 12 or under who (i) has the same principal place of abode as you, (ii) does not provide over half of his/her own support and (iii) is your "child" (son, daughter, grandchildren, stepchildren, brother, sister, niece and nephew). Note: There is a special rule for children of divorced parents. If you are divorced, the child is a qualifying individual with respect to you if the child lives with you even if you have permitted the non-custodial parent to take the personal tax exemption; or

- 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.

3. The expenses are incurred to enable you to be gainfully employed.

4. If the expenses are incurred for services outside your household for a Dependent who is age 13 or older, that Dependent must spend at least 8 hours a day in your home.

5. If the incurred expenses are for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and federal laws.

6. The expenses cannot be paid or payable to a child of yours who is under age 19 at the end of the year when the services were rendered or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

7. This reimbursement (plus all other Dependent Care reimbursements during the same year) may not exceed the least of the following limits:

- $5,000,
- $2,500 if you are married, but you and your Spouse file separate tax returns,
- Your taxable compensation (after your salary reduction under the Plan), or
- If you are married, your Spouse's actual or deemed earned income.

Your Spouse will be deemed to have earned income of $250 (for one Eligible Dependent) or $500 (for two Eligible Dependents) for each month the Spouse is either (1) physically or mentally incapable of personal care or (2) a full-time student. Your spouse is considered to be a full-time student if the spouse is deemed a full-time student by the "educational institution" attended by the spouse during each of five calendar months during a Plan Year. An educational institution is any educational institution that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your federal Income Tax" for further information or clarification.

Q-12 How do I submit a claim for reimbursement under the DCAP?

Under this DCAP, you have types of reimbursement options detailed below.

You can complete and submit a written claim for reimbursement ("Traditional Paper Claims"). When you incur an Eligible Employment Related 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 Service Provider. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g. a receipt or invoice) associated with each expense that indicates the following:

a) The date the expense was incurred

b) The amount of the expense.

The amount of your reimbursement will depend on your current Account Balance (deductions to date minus any previous reimbursements). If your Account Balance is equal to or exceeds your claim, your claim for eligible expenses will be reimbursed in full. If your claim exceeds your current Account balance, the excess part of the claim will be carried over into the following pay cycles to be paid as your balance can cover it. In other words, as additional salary conversion amounts are credited to your Account raising your Account Balance, a reimbursement check will be processed automatically for any unpaid portions of any properly submitted claims. Remember, no expenses can be reimbursed that exceed the payments you have made up to that date minus any previous reimbursements.

You cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Benefit Election Form becomes effective, or after the end of the Plan Year. You may be able to submit claims for reimbursement of an eligible expense incurred after the date that you terminate or cease to be eligible for this Plan up to your account balance on the date that you stopped being eligible. Also, no check will be written if the current amount payable to the Participant for claims is less than the Minimum Check Amount as specified in Part 8 below. The Minimum Check Amount will not apply for processing the final checks during any Plan Year.

At the end of the Plan Year, you will have a closing period (as stated in Part 8 below) to turn in claims for expenses incurred during the Plan Year. No claims can be submitted for reimbursement after the closing period ends. Your Employer may set a claims submission grace period for terminated employees; if so, you will find this information in Part 8 below.

You may, if enabled as a Plan option in Part 8, use the *Benefit Card* to pay the expense. In order to be eligible for the *Benefit Card*, you must agree to abide by the terms and conditions of the *Benefit Card* Program (the "Program") as set forth herein and in the *Benefit Card* Cardholder Agreement (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). The terms of the *Benefit Card*, if applicable, are set forth in Part 9 below.

Q-13 Will I be taxed on the DCAP benefits I receive?

You will not normally be taxed on your DCAP benefits up to the limits set out in Part 6, Q-7 and Part 6, Q-11. However, before you can qualify for tax-free treatment, you are required to list the names and taxpayer identification numbers of any persons providing your dependent care services during the calendar year for which you have claimed a tax-free reimbursement. (Be sure to fill out all the spaces on your claim!)

Q-14 Can I change my election if I change day care providers during the year and the rates are different?

Yes, this will be considered a Change of Coverage (see Part 2, Q-11). You will need to submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to change the day care provider and the rates.

Q-15 Can I change my election if a relative starts keeping my children for free?

Yes, this will also qualify for the Change of Coverage discussed above. You would submit a Change of Status Form changing providers with the rate being changed to zero. NOTE: You will not be able to change your election as a result of a cost increase or decrease imposed by a relative.

Q-16 What happens if I still have a balance in my DCAP Account at the end of the Plan Year?

Any unused amounts left in your Account at the end of the Plan Year cannot be carried over into the next year, but will be forfeited and returned to your employer to offset administrative expenses and future costs. Also, any uncashed reimbursement checks will be forfeited if not cashed within 90 days of issue.

Q-17 What happens if my claim for DCAP benefits is denied?

If you are denied a claim reimbursement under the Plan (e.g. election changes, eligibility for pre-tax benefits), you should proceed in accordance with the following claims review procedures. If you are denied a claim under one of the Benefit Package Options, you should proceed in accordance with the claims review procedures established for that particular Benefit Package Option.

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.

Step 2: Review your notice carefully. Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

The reason(s) for the denial and the Plan provisions on which the denial is based;

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;

A description of the Plan's appeal procedures and the time limits applicable to such procedures;

A right to request all documentation relevant to your claim.

Step 3: If you disagree with the decision, you may file an appeal. If you do not agree with the decision of the Plan Service Provider, you may file a written appeal. You should file your appeal no later than 180 days of receipt of the notice described in Step 1. If the Plan has established only one level of review, you should file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you should file your appeal with the Plan Service Provider. The notice of denial reference in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal. Regardless, 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 claims reviewer. If the claim is again denied, you will be notified in writing. If the plan has established two levels of appeal as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the Plan Service Provider. Otherwise, notice of the denial will be sent no later than 60 days after the appeal is received by the Plan Administrator.

Step 5: Review your notice carefully. You should take the same action that you take 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 there is a second level of appeal as indicated in the notice of denial): If you still disagree with the Plan Service Provider's decision, file a second level appeal with the Plan Administrator. If you still do not agree with the Plan Service Provider's decision, you may file a written appeal with the Plan Administrator within the time allotted for appealing as set forth in the notice of denial 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 will support your claim.

If the Plan Administrator denies your second 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 2 above.

Q-18 How do I receive my payment under the DCAP?

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 (this check may be written off a Plan Service Provider account; however, 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); (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)

Part 7. ERISA Rights

This Plan is not a welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA). However, certain component benefits (such as the Health FSA Plan) may be governed by ERISA. ERISA provides that you, as a Plan Participant, will be entitled to:

1. Receive Information about Your Plan and Benefits
   - Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
   - Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreement, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
   - Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
2. Continue Group Health Plan Coverage
   - Continue health coverage for you, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, you or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
   - Obtain reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage under another plan (if the Health FSA is subject to HIPAA). You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases (if you requested continuation coverage), before losing coverage (if you requested continuation coverage), or up to 24 months after losing coverage (if you requested continuation coverage). Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty

to do so prudently and in the interest of 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.

4. Enforcement of Your Rights

   If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. 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).

5. 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 Pension and Welfare Benefits Administration.

Part 8. *Benefit Card*

The Electronic Payment Card allows you to pay for Eligible Expenses as defined by the Plan(s) in which you participate at the time that you incur the expense. Here is how the Electronic Payment Card works.

(a) *You must make an election to use the card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to card usage (it can not be used at all MasterCard® acceptance locations and has no cash assess), the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you upon election of card use. The card will be effective the first day of each Plan Year unless you do not affirmatively opt-out of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

(b) *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. 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, you certify during the applicable Election Period that the amounts in your Plan will only be used for Eligible Expenses (i.e. medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(d) R*eimbursement under the card is limited to specific providers.* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.). Use of the card for DCAP expenses limited to merchants who are child card providers. Use of the card for other Plan expenses may be limited to merchants of qualified classifications. The card cannot be used at all MasterCard® acceptance locations.

(e) *You swipe the card at the provider like you do any other credit card.* When you incur an Eligible Expense at a qualified merchant, you swipe the card much like you would a typical credit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Plan (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Plan is being made is an Eligible Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source. If you are using the card for DCAP expenses, you certify that you are using the card for services already incurred (and the payment is not made in advance of the date services will be provided).

(f) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:

- The nature of the expense (e.g., what type of service or treatment was provided).
  If the expense is for an over the counter drug, the written statement must indicate the name of the drug. If the expense is for a DCAP payment, the written statement must indicate the tax id number of the provider.
- The date the expense was incurred.
- The amount of the expense.

You must submit third party receipts/statements to your Plan Administrator within the time frame specified at the inception of your plan. You must also retain a copy of this receipt for your own records for at least one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement is required to be submitted. Your card will be subject to deactivation if these guidelines are not met.

(g) *There are situations where the third party statement will not be required to be provided to the Plan Service Provider.* There are many situations in which you will not be required to provide the written statement to the Plan Service Provider. Situations in which you may not be required to submit the third party statement are determined by your Plan Administrator at the inception of your plan.

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 pay back 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 Administrator. 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 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 (as specified in the Cardholder Agreement) or the remaining unpaid amount will be included in your gross income as taxable "wages."

(i) *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

Part 9. Plan Information Summary

1. Employer Organization

Name of Organization:	**Data Electronic Devices, Inc.**
Federal Employer ID Number:	02-0350613
Address:	32 Northwestern Drive
City, State, Zip:	Salem, NH 03079

2. Plan Elections

Plan Number:	502
Plan Name:	**Data Electronic Devices, Inc. Section 125 Cafeteria Plan**
Original Effective Date:	1/1/2005
Plan Year Runs*:	January - December
Plan Document Amended & Restated:	January 1, 2007 (Increase in FSA Medical Maximum)

*This Plan is designed to run on a 12-month plan year period as stated above. A Short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan.

Plan Administrator:	**Data Electronic Devices, Inc.**
Plan Service Provider:	S & A, Inc.
Street Address:	50 Elm Street
City, State, Zip:	Manchester, NH 03101
Phone:	(603) 641-8100 (877) 641-8188
Benefits Coordinator	
Company Name:	**Data Electronic Devices, Inc.**
Street Address:	32 Northwestern Drive
City, State, Zip:	Salem, NH 03079
Phone:	603-893-2047
Contact:	Yvette Varney
Acceptance of Legal Process	
Company Name:	**Data Electronic Devices, Inc.**
Street Address:	32 Northwestern Drive
City, State, Zip:	Salem, NH 03079
Phone:	603-893-2047

The appointed Plan Service Provider in conjunction with the Administrator will perform the functions of accounting, record keeping, changes of participant family status, and any election or reporting requirements of the Internal Revenue Code.

3. Eligibility Requirements

Full Time employees will be eligible after 90 days of employment. Definition of Full Time employee is one who works 30 or more hours/week.

4. Plan Entry Date

The Plan Entry Date is the date when an employee who has satisfied the Eligibility Requirements may commence participation in the Plan.

5. Benefit Package Options

The following Benefit Package Options are offered under this Plan:

Core Health and/or Dental Benefits.

The terms, conditions, and limitations of the Core Health and/or Dental Benefits offered will be as set forth in and controlled by the Group/Individual Medical and/or Dental Insurance Policy or Policies.

Unreimbursed Medical Plans.

The terms, conditions, and limitations will be as set forth in and controlled by the Plan Document. Each year each participant may elect in writing on a form filed with the plan administrator on or before the date he first becomes eligible to participate in the plan, and on or before the first day of any plan year thereafter, to be reimbursed from the employer for Unreimbursed Medical Expenses incurred during that year by him to the extent described and defined in the Plan Document.

Dependent Care Plans.

The terms, conditions, and limitations will be as set forth in and controlled by the Plan Document. Each year each participant may elect in writing on a form filed with the plan administrator on or before the date he first becomes eligible to participate in the plan, and on or before the first day of any plan year thereafter, to be reimbursed from the employer for dependent care cost incurred during that year by him to the extent described in the Plan Document.

6. Flexible Spending Account Elections

The Closing Period is the period of time that begins after the Plan Year ends during which the employee can submit claims for payment of Qualified Expenses incurred during the Plan Year. This Closing Period begins at the end of the Plan year and terminates **90 days** after the end of the plan year.

The Claims Submission Grace Period is the period of time 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. The Claim Submission Grace Period begins on the employee's termination and ends 90 days after the date of termination.

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

Health FSA

(a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is **$5,000.00**.

(b) The maximum annual reimbursement amount that a Participant may receive during the year is the annual reimbursement amount elected by the Employee on the Salary Reduction Agreement for Health FSA coverage, not to exceed the amount set forth in (a) above.

(c) Minimum Contribution for this Benefit per Plan Year per Employee is $1.00.

(d) In order to receive reimbursement under the Health FSA, the claim or claims must equal or exceed the Minimum Check Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Check Amount, except that claims submitted for reimbursement during the last month of the Plan Year or during the Closing Period or Claims Submission Grace Period, whichever is applicable, will not be subject to the Minimum Check Amount. The Minimum Check Amount under this Plan is hereby set as $1.00.

(e) **COBRA Administrator: S & A, Inc.**

Street Address: 50 Elm Street

City, State, Zip: Manchester, NH 03101

Dependent Care Assistance Plan

(a) The maximum annual reimbursement amount a Participant may elect under the Dependent Care Assistance Plan for any Plan Year is the lesser of the maximum established by the Plan described in (b) below or the statutory maximum specified in Code Section 129 (as described in your summary plan description).

(b) The maximum annual reimbursement amount established by the Dependent Care Assistance Plan is as follows: $**5,000.00** for married filing jointly or single and $**2,500.00** for married filing separately.

(c) The maximum annual 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 amount in (a) above.

(d) Minimum Contribution for the Benefit per Plan Year per Employee is $1.00.

(e) In order to receive reimbursement under the Dependent Care Assistance Plan, the claim or claims must equal or exceed the Minimum Check Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Check Amount, except that claims submitted for reimbursement during the last month of the Plan Year or during the Closing Period or Claims Submission Grace Period, whichever is applicable, will not be subject to the Minimum Check Amount. The Minimum Check Amount under this Plan is hereby set as $1.00.

7. *Benefit Card*

As part of the Plan, a *Benefit Card* is offered to you as an alternative reimbursement method.

8. Incorporated By Reference

The actual terms and the conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and the Employer's Cafeteria Plan adopted through this Agreement as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.