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Pre-Tax Benefits Plan

Plan Detail Document (PDD)

Fact Sheet

Multiple Part Document Notice

Your complete Plan Detail Document (PDD) consists of two parts as outlined below. This description of the two-part construction of the combined PDD is intentionally repeated at the beginning of both the Fact Sheet and the Disclosure Document.

Part	Document Name	Description
Part #1	Fact Sheet	The Fact Sheet contains the details of the plan that are specific to your employer sponsored plan. It outlines which component plans your employer offers and defines all plan variables and terms referenced in the accompanying Disclosure Document.
Part #2	Disclosure Document	The Disclosure Document provides an outline of each of the component plans as well as a detailed explanation of the rules and requirements for each component. The Disclosure Document contains information on all potential pre-tax benefits. The specific components that offered by your Employer are identified in this Fact Sheet.
Addendum	HIPAA Privacy Notice	HIPAA Privacy Notice is consolidated with and appended to the end of this document for convenience and easy reference.

Section 1: Plan Sponsor Information

Plan Name:	Fremont Union High School District Pre-Tax Benefits Plan *The Plan Name is the overarching reference for all elements of the plan and is referred to as the "Plan" in the accompanying Description Document.*
Plan Number:	FEA
Employer/Plan Sponsor Name:	Fremont Union High School District *The Employer/Plan Sponsor is referred to as "Your Employer" in the accompanying Disclosure Document.*
Contact Information:	589 West Fremont Avenue Sunnyvale, CA 94087 (408) 522-2200
Affiliated Employers:	None
Employer Tax ID Number:	Confidential DO NOT USE ON MATERIALS (77-0012280)
Plan Effective Date:	January 1, 1999
Last Plan Update:	January 1, 2024
Plan Year:	January 1 to December 31
Plan Administrator:	Fremont Union High School District

	The Plan Administrator has authority to control and manage the operation and administration of the Plan.
Agent for Service of Legal Process:	Fremont Union High School District
Type of Cafeteria Plan:	Regular Cafeteria Plan
Coordinating Employee Benefits Plan:	The Fremont Union High School District Employee Benefit Plan *The underlying welfare benefits plan sponsored by Employer that provides employee benefits and health coverages to plan participants.*
Contractor for Administrative Services:	Vita Administration Company/Vita Flex 1451 Grant Road, Suite 200 Mountain View, CA 94040 (650) 968-8811 *The Contractor for Administrative Services is retained by the Employer/Plan Administrator to handle the day to day administration of the Plan and is referred to as "Vita" in Disclosure Document.*
Plan Fiduciary:	Employer/Plan Sponsor
Claims Fiduciary:	Vita Administration Company *The Claims Fiduciary is responsible for confirming claims eligibility, processing claims, and retaining document of eligibility for claims. The claims fiduciary stands alone in the responsibility for making claim eligibility decisions, but this role is different from the overall Plan Fiduciary.*
Funding Arrangement/Agent:	Self-Funded *The Funding Agent is responsible for payment of claims and holds financial risk for claims.*
Plan Changes or Termination:	The Plan Administrator may terminate, suspend, withdraw, amend, or modify any element of this Plan in whole or in part at any time, subject to the applicable provisions of the group benefit policies or corporate policies as outlined in the contracts, corporate minutes and/or bylaws.

Section 2: Eligibility Provisions

Eligibility Provisions:	**FSA**: Employees must be regularly scheduled to work 10 or more hours per week. **HSA & Commute**: Employees must be regularly scheduled to work 20 or more hours per week.
Initial Waiting Period:	**FSA & Commute:** Employees become eligible on the first contractual work day. **HSA:** Enrolled employees become eligible to contribute on the first of the month following or coinciding with the date of hire.
Excluded Classes of Employees:	**FMA** employees are not eligible to participate in the HSA. **CSEA** employees are not eligible to participate in the FSA or HSA.

Section 3: Plan Components Included

Premium Contributions ☑ Yes ☐ No

Health Flexible Spending Account (FSA)	☑ Yes	☐ No
Dependent Care Flexible Spending Account (FSA)	☑ Yes	☐ No
Commute Benefits	☑ Yes	☐ No
Health Savings Account (HSA)	☑ Yes	☐ No

Section 4: Plan Component Details

Premium Contributions	Flex Credit Dollars:	☐ Yes ☑ No
Federal Maximum plan contributions:	This section applies to employee plan contributions and Health FSA balance rollovers. Federal maximums are announced by the IRS in October or November each year for the following Plan Year. The maximum annual election amount and the maximum allowed rollover amount may not be announced until after the creation of this Fact Sheet each year and after your Employer holds your open enrollment period. The specific maximums are outlined in other Vita Flex election materials each year. All elections that are made for the maximum amount will be adjusted to reflect any increase in the maximum amount allowed by the IRS for the next Plan Year. Elections that are made below the maximum annual election amount will not be changed. Please refer to https://help.vitacompanies.com/knowledgebase/article/KA-01239/en-us for the most up-to-date Federal Maximums.	
Reimbursement Method:	Direct Deposit or Check	

Health FSA Component:	Minimum Election:	$0 per Plan Year
	Maximum Election:	Federal Maximum
	Employer Match:	None
	Debit Card Provision:	☑ Yes ☐ No
	Mobile App Provision:	☑ Yes ☐ No
	Rollover Provision:	☑ Yes ☐ No
	Rollover Minimum Balance Requirement *if not actively electing Health FSA in the following Plan Year*:	No minimum balance requirement
	Rollover Maximum:	Federal Maximum Rollover Amount
	Grace Period Provision:	☐ Yes ☑ No
	Claim Incurred Deadline:	December 31
	Claim Submission Deadline:	March 31 of the following year
	Plan Funding:	Participant contributions

Dependent Care FSA Component:	Minimum Election:	$0 per Plan Year
	Maximum Election:	Federal Maximum
	Debit Card Provision:	☐ Yes ☑ No
	Mobile App Provision:	☑ Yes ☐ No
	Grace Period Provision:	☐ Yes ☑ No
	Claim Incurred Deadline:	December 31
	Claim Submission Deadline:	March 31 of the following year
	Plan Funding:	Participant contributions

Commute Benefits Component:	Pre-Tax Parking Maximum:	Federal Maximum
	Post-Tax Parking Maximum:	No limit
	Pre-Tax Transit Maximum:	Federal Maximum
	Post-Tax Transit Maximum:	No limit
	Debit Card Provision:	☑ Yes ☐ No
	Mobile App Provision:	☑ Yes ☐ No
	Employer/Plan Sponsor Contribution:	Parking - None Transit - None
	Plan Funding:	Participant contributions

Health Savings Account (HSA) Component:	Maximum Contribution:	Federal Maximums* *If age 55 or over, you may contribute an additional $1,000 per year
	Employer/Plan Sponsor Contribution:	For Employees who are enrolled in the employer-sponsored High Deductible Health Plan (HDHP), the Employer will make contributions to the HSA in the following amounts, based on HDHP enrollment level: The prorated annual Employer Contribution will be divided into monthly amounts and credited to the HSA on each payroll date, per the Employee's payroll schedule. Individual - $1,700/yr (prorated) Family - $3,400/yr (prorated) Upon termination, the final Employer contribution will be made on the first of the month in which the Employee's plan is terminated.

Maximum Employer Contribution:	Individual - $1,700/yr Family - $3,400/yr
Debit Card Provision:	☑ Yes ☐ No
Mobile App Provision:	☑ Yes ☐ No
Plan Funding:	Participant contributions and Plan Sponsor general assets

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Pre-Tax Benefits Plan

Plan Detail Document
Disclosure Document

Two-Part Document Notice

Your complete Plan Detail Document (PDD) consists of two parts as outlined below. This description of the two-part construction of the combined PDD is intentionally repeated at the beginning of both the Fact Sheet and the Disclosure Document

Part	Document Name	Description
Part 1 of 2	Fact Sheet	The Fact Sheet contains the details of the plan that are specific to Your Employer sponsored plan. It outlines which component plans Your Employer offers and defines all plan variables and terms referenced in this Disclosure Document.
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Table of Contents

Section 5: Components of the Plan

Your Employer is pleased to sponsor an employee benefit program known as the Pre-Tax Benefit Plan (the Plan) for the benefit of eligible employees. The purpose of this Plan is to leverage the opportunities provided by the Internal Revenue Service for employees to use and receive pre-tax dollars rather than taxable dollars, and thus save taxes.

This document summarizes the details of all the potential pre-tax options available under the IRS Code for employers. Your Employer may have selected all or only some of these plan components. To confirm which of the plan options offered by Your Employer, please refer to the accompanying PDD Fact Sheet. If a specific benefit component is not outlined in the accompanying PDD Fact Sheet, that benefit component is not included in your pre-tax plan.

Each of the various pre-tax options has a unique set of rules and requirements, but all offer the ability to legally save taxes. This Plan has been established with the intention of qualifying under specific IRS Code section references and the regulations issued thereunder. Following is a brief description of the plan component options and the IRS Code sections under which each is governed.

Plan Components	IRS Code
1. Premium Contribution. This component allows you to pay your premium contributions on a pre-tax basis and have your health expenses and/or dependent care expenses reimbursed on a pre-tax basis. The required contributions are taken from your compensation as a salary reduction and are then used by Your Employer to offset your portion of the premiums for coverages you have elected. Your election to participate in the premium contribution portion of this component is a perpetual election and does not need to be made each Plan Year.	§125
2. Health Flexible Spending Account (health FSA). This component allows you to elect a specified amount each year to set aside for health care expenses. Your compensation will be reduced by the elected amount in lieu of receiving the money as regular pay. Upon incurring an eligible expense, you may then be reimbursed from your own account for those health care expenses on a tax-free basis.	§125 §105
3. Dependent Care Flexible Spending Account (Dependent Care FSA). This component allows you to elect a specified amount each year to set aside for dependent care expenses. Your compensation will be reduced by that amount in lieu of receiving the money as regular pay. Eligible dependent care expenses include costs to pay for childcare so that you can work. Upon incurring an eligible expense, you may then be reimbursed from your own account for those health care expenses on a tax-free basis.	§125 §129
4. Health Reimbursement Arrangement (HRA). This component is an employer-funded account from which you can request reimbursement of eligible health care expenses. The type of expenses that are eligible may vary as they are defined by Your Employer. This component is intended to be a health reimbursement arrangement as defined under IRS Notice 2022-45. This Plan is not intended to be integrated with Medicare Parts B and D.	§105 §106
5. Health Savings Account (HSA). This component allows you to make contributions to a Health Savings Account (HSA) on a pre-tax basis. You personally own your HSA, and you may make personal contributions directly to your account and take a tax deduction on your personal tax return. However, this component also allows you to make contributions to your HSA through Your Employer on a pre-tax basis. When you make a contribution through Your Employer, your compensation will be reduced by that amount in lieu of receiving the money as regular pay. Reimbursements or payments may be made from your account to pay for eligible health care expenses. Since it is your personal account, you	§223

manage payments and/or reimbursements from your account. You must retain documentation for any health care expenses that you take out of your account.

6. Commute Plan. This component allows you to pay for commuting expenses including public transit and parking expenses with pre-tax dollars. You elect payroll salary reductions in the amount of your qualified commute expenses and are thus able to convert commute expenses to tax-free expenditures. §132

7. Simple Cafeteria Plan. If Your Employer made a Simple Cafeteria Plan election, Your Employer is required to make a contribution to provide qualified benefits under the Plan on behalf of each qualified employee. The contribution can be towards medical, dental, or vision premiums, a health FSA, or a Dependent Care FSA. §125 §105 §129

8. Lifestyle Spending Account. This component provides taxable reimbursements for wellness or other life expenses as designated by Your Employer. Since these expenses are not eligible for pre-tax treatment, there is no code section reference. N/A

Exclusive Benefit

The Plan and each component benefit adopted is established for the exclusive benefit of Participants, their covered dependents, and their beneficiaries, and is administered impartially for the benefit of all eligible employees.

Roles of Parties

The Plan Sponsor may direct the Contractor for Administrative Services to perform, solely in a ministerial capacity, any of the administrative procedures described herein on its behalf.

Section 6: General Information about Pre-Tax Plans

Q-1. What is Vita Flex?

Vita is the name of the administrator which Your Employer has contracted to administer the Pre-Tax Benefits Plan, and Vita Flex is the brand name of the Pre-Tax Benefit Plan administration platform. The IRS allows these pre-tax plans, but they also impose numerous rules and restrictions and require that employers sponsoring plans ensure that they are compliant with those rules. As an administrator, Vita has been hired by Your Employer to administer the Plan in a manner that is compliant with rules and regulations. It is also our goal to make your experience as a participant as smooth and easy as possible. We acknowledge that sometimes the rules imposed by the IRS are inconvenient for Plan participants. It is our goal to make the experience as streamlined as possible within the boundaries of the regulations to which the Plan is bound.

Q-2. What are the benefits of the Pre-Tax Benefits Plan?

The Plan allows you to convert taxable dollars into tax-free dollars for certain eligible expenses. The amount you authorize to withhold from your earnings on a pre-tax basis will not count as taxable income for federal or Social Security tax purposes. In some states, state income tax is also avoided. The rules regarding the taxation of amounts withheld from your salary or wages for federal, state or local income tax purposes are subject to change.

Q-3. How do the tax savings work?

The example below shows the savings potential of someone earning $75,000 per year with a monthly budget of $500 for health and dependent care expenses, $200 for medical plan contributions, and $150 for commute expenses. An approximate annual tax savings of $3,468 is available, just by participating in the Pre-Tax Benefits Plan. The example below illustrates a conservative estimate of tax savings based on low tax rates and two exemptions. The higher your tax bracket, the more you can potentially save by participating in the Plan.

	Without Participation	With Participation	
Monthly Salary	$6,250	$6,250	
Actual Expenses – Funded Pre-Tax			
Premium	$ 0	$ 250	
Health	$ 0	$ 100	
Dependent Care	$ 0	$ 400	
Commute	$ 0	$ 150	
Total Expenses	$ 0	$ 900	
Net Taxable Income	$6,250	$5,350	
Taxes			
Federal Income Tax (25%)	$1,562	$1,337	
State Income Tax (9% Estimated)	$ 562	$ 481	
Social Security/Medicare Tax (7.65%)	$ 478	$ 409	
Projected Taxes	$2,602	$2,227	
Income After-taxes	$3,649	$3,123	
Actual Expenses – Funded After-tax			
Premium	$ 200	$ 0	
Health	$ 100	$ 0	
Dependent Care	$ 400	$ 0	
Commute	$ 150	$ 0	
Total Expenses	$ 900	$ 0	
Net Take Home Pay	$2,749	$3,123	
Net Pay Increase (Monthly)		$ 374	
Net Pay Increase (Annual)		$4,488	*Tax Savings*

Q-4. Who is eligible to participate?

To become a Participant in the Plan you must be an Eligible Employee as defined in the PDD Fact Sheet.

Eligible Employee means an individual classified as a common-law employee and who is on Your Employer's W-2 payroll, except that the term does not include any leased employee, or any individual classified by Your Employer as a contract worker, independent contractor, temporary employee, or casual employee.

Certain other Employees are not eligible to participate in the Salary Reduction, health FSA, Dependent Care FSA, HRA, and Commute components of the plan. Such Employees include any individual who performs services for Your Employer but who is paid by a temporary or other employment or staffing agency (leasing agency), contract workers, any employee covered under a collective bargaining agreement, any self-employed individual, any partner, general partner in a partnership, or any more-than-2% shareholder of a Subchapter S corporation.

Eligible Employees must regularly and consistently work the required number of hours specified in the PDD Fact Sheet and have satisfied the required waiting period. Employees are eligible to participate in the Plan upon becoming eligible for any of the contributory health (and other) insurance benefits or component parts of this Plan.

Those Eligible Employees who actually participate in the Plan and their eligible dependents are called "Participants". If you elect to participate in the Plan, you become a Participant on the first day of the first Period of Coverage that begins on or after the day you become an Eligible Employee, pursuant to Your Employer's eligibility requirements specified in the PDD Fact Sheet.

An employee continues to be a Participant until:

- You elect not to participate in accordance with the Plan; or

- You are no longer employed by Your Employer; or
- You are employed, but no longer meet the criteria of Eligible Employee to participate in the Plan; or
- Continuation Coverage (as described in this document) is no longer in effect; or
- Your account balance is zero; or
- The Plan terminates.

Q-5. When can I start participating?

Your election becomes effective after the waiting period that is specified in the PDD Fact Sheet, assuming you have made your formal election prior to that date. You must complete your enrollment within 30 days of your initial effective date.

Q-6. What are the rules around elections?

Initial Elections. The Plan uses a Plan Year Period of Coverage for the Premium, FSA, and HRA components of the Plan. The Plan uses a calendar month Period of Coverage for HSA and Commute components. You must complete your election and Salary Reduction Agreement before the first day of a Period of Coverage in order to receive benefits for that Period of Coverage.

Timing. Your election must be made before (1) the date on which the Period of Coverage to which the election relates commences, and (2) the date on which the benefit to which it relates are provided. In short, no retroactive elections are permitted, only prospective elections.

Automatic Renewal. Premium, Commute, and HSA benefits automatically renew for subsequent Periods of Coverage until you submit a new Election Form/Compensation Reduction Agreement. However, Salary Reductions and contributions made by Your Employer will end if you cease to be an Eligible Employee.

No Automatic Renewal. Health FSA, Dependent Care FSA, and HRA benefits do not automatically renew, unless specifically identified so in the Your Employer's Open Enrollment communication materials.

Q-7. How do I enroll?

Enrollment guidelines are outlined in the benefits enrollment materials provided by Your Employer. One of three methods is typically available to you:

- Online through Your Employer's benefits enrollment system
- Online through the Vita Flex web portal
- Paper enrollment form

The specific enrollment methods available to you will be outlined by Your Employer. Regardless of the enrollment method, you must complete your enrollment within 30 days of your eligibility date (usually your hire date plus any waiting period). Your election will not become effective until Your Employer processes your enrollment. The enrollment process identifies your plan elections and authorizes Your Employer to withhold amounts elected from your salary in an amount equal to your elections for each plan.

Q-8. How do Salary Reductions work?

Certain components of the Plan allow and/or require employee contributions. When required or allowed, all such contributions are made via a Salary Reduction Agreement, whereby your gross compensation is reduced by the amount that you elect to contribute to each Plan component. For FSA plans, your annual election is divided equally between your scheduled pay periods.

Q-9. What is a Plan Year?

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year is typically January 1st through December 31st. Please refer to the PDD Fact Sheet for Your Employer's specific Plan Year. Should Your Employer's Plan start mid-year, your Plan will run from the start date of the Plan through the end of the Plan Year as outlined in the PDD Fact Sheet.

Q-10. Will participation affect my Social Security benefits?

Participating in any pre-tax plan may affect your future Social Security benefits, as well as other wage-based social benefits. Participation reduces the amount of your taxable compensation (except for the HRA component). Thus, both you and Your Employer pay Social Security taxes on a lower amount of wages (assuming your income is below the taxable wage base). This could result in a decrease in your future Social Security benefits. Additionally, any other wage-based benefits (such as retirement, disability, or life insurance benefits) which are determined based on your taxable compensation may also be affected by participation in this Plan.

Q-11. What modifications can my Employer make to my elections?

The Administrator may, at any time, require you to amend the amount of your elections for a Plan Year if the Administrator determines it is necessary or advisable to satisfy any non-discrimination requirements or any limitation imposed by the IRS Code applicable to any of the components of this Plan. This may be necessary in order to maintain the tax-qualified status of benefits received under this Plan, or for any reason to satisfy the requirements of administering this Plan. Additionally, if during the Plan Year, the cost of benefits provided under the Employee Benefits Plan (your other health and welfare benefit plans provided by an independent insurance carrier or third party administrator) that you have elected changes, your benefit election shall automatically be adjusted to reflect such premium change or subsequent required contribution change. You will not be permitted to change coverage during a Plan Year because of change in the cost of coverage, except as otherwise provided for in this Plan Detail Document under the rules for changing elections. Any modifications made will be carried out in a uniform and non-discriminatory manner.

Q-12. How do the discrimination rules work?

The IRS rules require that the Plan be non-discriminatory, which means it cannot provide benefits which favor highly compensated or Key Employees as to benefits provided or eligibility to participate.

Therefore, if necessary, the Plan 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). These generally include officers, shareholders, and highly paid employees. If the Plan Administrator determines that the Plan does not satisfy the non-discrimination requirements, benefit concentration tests or the benefit limitations of the Code, the Plan Administrator will take appropriate action to ensure compliance, including but not limited to modifying on a non-discriminatory basis, the elections of the highly compensated employees or Key Employees without their consent. If a benefit election is reduced or not allowed, it is treated as taxable compensation to the Employee. This action would be taken only to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law. If Your Employer has made a Simple Cafeteria Plan election, the discrimination testing requirements will not apply to your plan.

Q-13. Do I need to pay any administration costs?

Your Employer typically sponsors the full cost of administering the Plan. In some instances, you may be required to pay a small amount to participate in a specific Plan component or, in some instances, if you elect a particular method of reimbursement or plan communication (typically paper/mail/check instead of e-mail/website/direct deposit). Please note that any such charges will be taken out of your reimbursement account election on a pre-tax basis. Details about any required administrative charges will be outlined in the benefits enrollment information.

Q-14. How will I receive Plan communication?

Generally, there are two methods for Pre-Tax Plan communication:

- Encrypted (Secure) E-mail
- E-mail Notification (Unsecure) with a link to a secure website

Both methods require an e-mail address and for participants to establish a login and a password to access plan election and reimbursement information. This is required for both dissemination of plan information as well as for information security purposes.

Standard notifications include welcome notifications, claims status/processing notifications, reimbursement notifications, and answers to any questions sent to the Vita Concierge (help@vitamail.com). You will be required to choose a Username and Password in order to access Vita communication. Please note that this is a secure method of electronic communication and has been approved by regulators as effectively safeguarding your Protected Health Information (PHI). Any e-mail communications or notifications sent over e-mail that contain PHI will be sent encrypted. The HIPAA law does not allow for opting out of HIPAA Privacy and Security rules, therefore, you may not elect to receive e-mails unencrypted, even if that would be your personal preference.

In some cases, employers may offer the option of hard copy communications mailed via the U.S. Postal Service. Even if Your Employer offers this option, the default election for every participant is via e-mail notification. If Your Employer offers the mailed communication method, you may change your preferred communication method by notifying Vita. If you elect this option, you will receive all Plan communication via first class mail through the U.S. Postal Service. As such, you accept any potential risks or delays associated with using hard copy mail as your primary Plan communication method. Please note that Your Employer is charged for every piece of Plan communication under the hard copy mail option. Your Employer and the Vita Administration Team would like to encourage you to elect to receive Plan communication via the electronic method, as it is a more cost-effective and environmentally-friendly option.

Q-15. How long will the Plan remain in effect?

Your Employer expects to maintain the Plan indefinitely and has the right to amend, modify, or terminate the program at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-16. Are the provisions of this Plan a promise of employment?

No. None of the components of the Plan or benefits provided through this Plan should be considered contracts for employment between you, as the employee or plan participant, and Your Employer. This Plan does not guarantee any employee or Plan Participant the right of continued employment and is not an employment contract. Additionally, this Plan does not limit Your Employer's right to discharge you or any Plan Participant. The Plan is not to be construed as giving you any rights against the Plan except those expressly described in this document.

Q-17. What is discretionary authority?

Vita administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits. Failure to enforce any provision of the Plan shall not affect Vita's right to later enforce that provision or any other provision of the Plan. Vita may delegate some of its administrative duties to agents.

Q-18. Is my health information kept secure?

Group health plans, including this Plan, are required to take steps to ensure that certain Protected Health Information (PHI) is kept confidential. You may receive a separate notice from Your Employer that outlines its health privacy policies, including with regard to electronic PHI. The law that governs the Privacy and Security of your Protected Health Information is HIPAA, the Health Insurance Portability and Accountability Act of 1996.

Q-19. May I assign my benefits?

No Benefit payable at any time under the Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Q-20. What if there is an error or overpayment?

If it is determined that you or any dependents received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the Plan. If you do not refund the overpayment or erroneous payment, the Plan and Your Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.

Q-21. What happens if my Employer goes out of business?

It is important to understand that the pre-tax salary reductions made from your compensation are held as a general asset of Your Employer. Salary reductions are not set up in a separate trust that is protected from business creditors. If you make contributions for any of the Plan components and Your Employer goes out of business, you may lose those contributions, if you have not already received reimbursement for eligible expenses or if contributions are not forwarded to the insurance carrier, your HSA investment vendor, or your commute/transit authority prior to a bankruptcy proceeding.

Section 7: Election Change Rules

This section only applies to the Premium component, health FSA component, and Dependent Care FSA components of the Plan.

Q-1. Can I change my elections during the Plan Year?

Generally, no. The Plan requires that you make an irrevocable election for the entire Plan Year and you may not change it during the Plan Year. You may always change your pre-tax elections at the beginning of each new Plan Year (at Open Enrollment). Except as outlined below under the election change rules, you may not change your election in any of the following ways during the Plan Year:

- Your participation in this Plan,
- Your Salary Reduction amounts, or
- Your election of specific coverages under the Employee Benefit Plan

In short, you may only change your salary reduction (and thus your coverage election) once per year at the annual Open Enrollment time. Importantly, there are some specific exceptions to this irrevocability rule as outlined below.

Q-2. What are the exceptions to the No-Election-Changes rule?

You may revoke or change your election if you experience a Status Change (major life event, specifically defined) or other Qualified Mid-Year Exception.

Q-3. What must I do to change my election?

Any change in your election must be submitted in writing or through an approved electronic format and must be received by Your Employer in a timely manner. An election change must be received prior to the new Plan Year for annual Open Enrollment, or within 30 days of the Status Change or other Qualified Mid-Year Exception that would allow you to change your election (or within 60 days for certain events as described under HIPAA Special Enrollments in this document). All changes must be prospective and may not be applied retroactively. If you do not request a change within 30 days of the Status Change or other Mid-Year Exception (or within 60 days as described under the HIPAA Special Enrollment Rights below), your right to change your election is forfeited and you must wait until the next annual Open Enrollment period to make any election change. Your new election will become effective as of the first pay period after the change is processed.

Q-4. What is a "Status Change"?

If you experience a Status Change, you may revoke or change your election for the remainder of the Plan Year. A Status Change is very strictly defined and must fall into one of the following categories:

- Marital Status Change. This includes any legal change to your marital status including, marriage, divorce, death of spouse, legal separation, and annulment.
- Tax Dependent Change. This includes any change in the number of tax dependents, including birth, adoption, placement for adoption, and death.
- Employment Status Change. This includes any change to your employment status that impacts your eligibility for employee benefit plans. This encompasses any event that would change your employment status, your spouse's employment status, or your dependents' employment status, including termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, or a change in worksite. The change in employment status must trigger benefit eligibility or ineligibility.
- Dependent Eligibility Change. This includes if your dependent satisfies (or ceases to satisfy) the dependent eligibility requirements of the health plan, including attainment of maximum age under the employee benefit contract, gain or loss of student status, marriage, or any similar circumstance.
- Adoption. This includes commencement or termination of adoption proceedings.

Any election change resulting from a Status Change requires that the revocation or new election must be consistent with the Status Change. To be considered consistent, a benefit election change must be both on account of and correspond to the Status Change. Additionally, in order to qualify as a Status Change, the change must affect coverage eligibility of the employee, spouse or dependent under an employer's Health Plan. If eligibility for benefits is not affected, then the change does not qualify as a Status Change.

Q-5. What is a Qualified Mid-Year Exception?

There are several other exceptions to the irrevocability of election rules. These are collectively called Qualified Mid-Year Exceptions as they are events that allow you to make a change in your election. Following is the list of defined events:

- Cost Change with Automatic Increase/Decrease in Contributions. If the Employee Benefit Plan you elect has a premium change, either mid-year or coinciding with the Plan Year, your Salary Reduction

election may be automatically increased or decreased by the Administrator to cover your new required share of the premium. (This exception does not apply to health FSAs.)

- Significant Change in Cost or Change in Coverage/Spousal Coverage. If you or your spouse experience a significant change in cost or coverage, you may revoke or modify your benefit election and/or participation in the Employee Benefit Plan for the remaining portion of the Plan Year. This may occur if you experience a significant change in cost or coverage or if the election period under a spouse's plan is different from yours. The change will be effective coincident with the effective date of the change in cost or coverage, provided notification is given within 30 days of such change. This assumes the revocation and new election are on account of a significant increase in the premium of your original coverage or if such original coverage is significantly curtailed or ceases. This includes Medicare and Medicaid entitlement. (This exception does not apply to health FSAs.)

- FMLA Leave. You may revoke or change your benefit election and/or participation in the Employee Benefit Plan coverage for the remaining portion of the Plan Year as may be provided for under FMLA (the Family and Medical Leave Act of 1993) if your FMLA leave impacts your benefits eligibility. If your FMLA leave does not impact benefits eligibility, your leave will not qualify for an election change. The new election is effective as of the pay period following the date of FMLA leave. (This exception does not apply to the Premium portion of the Plan. It applies only to health FSAs or Dependent Care FSAs.)

- HIPAA Special Enrollment Rights. You may revoke and/or change your benefit election and/or participation in the Employee Benefit Plan coverage during a Plan Year for the remaining portion of the Plan Year if you experience any of the following types of events as required by HIPAA and CHIP (Children's Health Insurance Program). (This exception does not apply to health FSAs or Dependent Care FSAs. It applies only to the Premium portion of the Plan.) Election changes must be made within 30 days of the event (except as noted below under termination of Medicaid or State CHIP Coverage).

  - ✓ Special Enrollment for Loss of Coverage. The employee or dependent must have lost other group health Plan coverage because COBRA benefits are exhausted, because other non-COBRA group coverage terminated due to loss of eligibility for coverage, or because employer contributions for the non-COBRA group coverage were terminated.

  - ✓ Special Enrollment for Acquisition of New Dependent. The employee must acquire a new dependent by birth, marriage, adoption, or placement for adoption. The special Open Enrollment right for a newly acquired dependent applies to the employee, the employee's spouse, and the newly acquired dependent.

  - ✓ Termination of Medicaid or State CHIP (CHIP) Coverage. Such coverage termination must be as a result of a loss of eligibility. The employee must request to change their election within 60 days of termination of Medicaid or SCHIP coverage. The election will be effective on the date that the corresponding health coverage begins. Please note that this Special Enrollment Right only allows an employee to enroll themselves or a qualified dependent.

  - ✓ Premium Subsidy. Becoming eligible for a premium assistance subsidy in the employer-provided group health plan under Medicaid or CHIP. The election will be effective on the date that the corresponding health coverage begins. Please note that this Special Enrollment Right only allows an employee to enroll themselves or a qualified dependent.

- Judgments, Decrees or Court Orders. You may revoke and/or change this benefit election and/or your participation in the Employee Benefit Plan coverage during a Plan Year for the remaining portion of the Plan Year pursuant to a judgment, decree, or court order resulting from divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order).

- Reduction of Hours. You may revoke your benefit election and/or your participation in the Employee Benefit Plan coverage during the Plan Year under the following reduction of hours circumstance. You may drop group health plan coverage midyear if you were expected to average at least 30 hours of service per week but your status changes such that that you are expected to average less than 30 hours of service. You may drop your coverage even if the reduction of hours does not result in loss

of eligibility for the Plan. However, the change must correspond to your intended enrollment (and the intended enrollment of any dependents on the Plan who whose coverage will also be dropped) in other minimum essential coverage as defined under the Affordable Care Act. The new coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped. You must make a certification to Your Employer of your intent to enroll in other coverage.

- Exchange Coverage. If you are eligible to enroll in Exchange coverage (during an Exchange special or Open Enrollment period) you may drop group health plan coverage midyear, but only if the change corresponds to your intended enrollment (and the intended enrollment of any dependents on the Plan who whose coverage will also be dropped) in Exchange coverage that is effective no later than the day after the last day of the original coverage. You must make a certification to Your Employer of your intent to enroll in other coverage. For plans that operate on a non-calendar year basis, if you have dependents that become newly eligible to enroll in a Qualified Health Plan under the Exchange, you may revoke family coverage under this plan to enroll your dependents in coverage through the Exchange and change your election to self-only coverage under this plan.

Q-6. Are there any exceptions to these mid-year exception rules?

Yes, in rare instances, a health insurance carrier may restrict the list of qualified events that allow for a mid-year change in your election to only a subset of those outlined above. When this is the case, the more restrictive list (which would be found in the health insurance carrier certificate of coverage) will define the eligible events, not this Plan Detail Document (PDD). This typically only occurs with small group health contracts (policies for employers with less than 100 employees).

Section 8: Premium Contribution Benefits

Q-1. What is the advantage of the Premium component of the Plan?

The premium contribution portion of the Plan allows you to pay the required contributions for the health insurance coverage(s) that Your Employer makes available to you by reducing your compensation. This means that your contributions are made before federal income taxes, state income taxes (in most cases) and Social Security taxes are withheld. In other words, the Plan allows you to use tax-free dollars to pay for insurance coverage and premium expenses which you normally pay for with out-of-pocket, taxable dollars.

Q-2. How are Premium Contributions made?

Before each Plan Year begins, you select the insurance coverage you desire. Then, during each pay period, contributions will be made automatically on your behalf as salary reductions from your compensation and used by Your Employer to pay the premium expense for the qualified group sponsored insurance coverage you have. The premium contributions are NOT part of the health FSA portion of this Plan, nor are group or individual premium contributions reimbursable under the health FSA portion of this Plan. Required premium contributions are taken out of your paycheck on a pre-tax basis, assuming you have not opted out of having them taken on a pre-tax basis. You may elect to have premiums taken on a pre-tax basis (opting into the plan) or on an after-tax basis (opting out of the plan) each year at Open Enrollment. New elections must be made during the "election period" prior to the beginning of each Plan Year. Your premium contributions are made in substantially equal amounts throughout the Plan Year and not in lump sum payments or unequal payments throughout the Plan Year unless there is an administrative error or other Plan provisions that justify an alternative method of unequal salary reductions.

Q-3. When must elections be made?

If you are a newly eligible employee, you must make your elections within 30 days of your initial eligibility date. At the annual Open Enrollment time, you must make your elections prior to the new Plan Year during the Annual Open Enrollment Period. Your Employer will specify the detailed process and timing for coverage and premium elections during the Open Enrollment period each year. Generally, your health plan elections will roll over from year to year; however, Your Employer may, in certain years, require that you participate in a positive enrollment process.

Q-4. What does "Use It or Lose It" mean?

The most important Plan restriction is the "use it or lose it" rule. You must carefully estimate your annual dependent care expenses *prior* to your election. If you over-estimate your expenses and do not actually incur your estimated eligible dependent care expenses by the Claim Incurred Deadline, your unused salary reduction contributions will be forfeited at the end of the Plan Year.

Q-5. Can I change my election?

Generally, no. Your health FSA election is generally deemed to be irrevocable for the Plan Year. That said, there are some specific circumstances when you can make a change to your election. Please refer to Section 7 of this PDD Disclosure Document for full details on the rules for changing your election.

Q-6. What happens if I elect not to participate in this Plan?

Any portion of your compensation for which you do not choose to make a salary reduction and apply toward your premium contributions for available coverages will be paid to you in full as regular, taxable compensation.

Q-7. Do I need to elect coverage every year?

Your election to have your premium contributions taken pre-tax via salary reduction is a perpetual election. To take advantage of the pre-tax contributions, you do not need to re-elect each year. Pre-tax salary contributions are the default and will be assumed unless and until you expressly revoke your election. While your coverage election and subsequent pre-tax premium election is perpetual, you do have the opportunity to make new coverage elections on an annual basis.

Q-8. How much are my premium contributions?

Your Employer will outline your premium contributions in the enrollment materials. Premium contributions are subject to change on an annual basis. The current contribution amounts can be found in both the enrollment documents and materials that outline the plans at your initial enrollment as well as in annual Open Enrollment communications.

Q-9. How do waiver stipends or opt-off credits work?

In some cases, Your Employers may offer a waiver stipend or taxable credit payable to you if you opt out of certain health insurance coverages. Any such stipends are subject to change on an annual basis, just as are premium contributions. It is important to understand that any such taxable payment or waive-off credit is subject to all the election rules of this Plan, including the election irrevocability rule, the requirement that a change may only be made in the event of a qualified reason, and the plan discrimination rules.

Q-10. What changes can be made to my contributions?

On an annual basis, Your Employer may make changes to the contribution amounts required for you to elect certain coverages. You will be given the opportunity to change your elections on an annual basis (at Open Enrollment). If you do not proactively make any changes, your coverages will remain the same and your premium contributions will automatically be increased to the newly required contribution amounts for the coverage(s) you have elected. In some years, Your Employer may provide specific instructions that there is no passive Open Enrollment, and you must affirmatively elect new plans and coverages.

Q-11. What are the enrollment periods for entering the Plan?

The annual Open Enrollment period begins approximately one to three months prior to each new Plan Year. Generally, you will receive annual Open Enrollment materials between October and early December prior to each new Plan Year, depending on the specific Open Enrollment period that Your Employer has arranged. If you do not receive these materials in a timely manner, you must request them from the Plan Administrator. Please do so at least ten (10) days prior to beginning the new Plan Year so that you may make a prospective election for the new Plan Year.

Q-12. What if I terminate my employment?

If your employment with Your Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make contributions to the Plan for the period of time after your termination date. Upon your termination of employment, pre-tax salary reductions will cease. However, in some cases, a salary reduction may be made in your final paycheck (which may actually be after your date of termination) to reflect coverage prior to your termination date.

If you terminate employment mid-year and are rehired within 30 days (or if you lose eligibility for the Plan due to an unpaid, non-FMLA leave), your participation is restricted to stepping back into your prior election for the Plan Year. You are not required to make up any missed salary reductions, however any claims incurred while you were not an active employee will not be eligible.

If you terminate employment during the Plan Year and are rehired outside of 30 days, you will be treated as a new hire. You will be subject to the waiting period and will be required to make a new election for the period of time left in the Plan Year. For health elections, claims must be incurred within the specific eligibility period for each separate election. The overall maximum amount that you can elect for a health FSA (between multiple elections in the same Plan Year) will be determined based on Your Employer's Plan design which is listed in Part 1, the PDD Fact Sheet, of this document. For the Dependent Care FSA, you will not be allowed

to elect more than the IRS set maximum for the Plan Year. Please contact your benefits department or the Vita Concierge for more detailed information.

Q-13. How does the Plan coordinate with the Family and Medical Leave Act?

In general, under the Family and Medical Leave Act of 1993 (FMLA), employers with 50 or more employees are required to offer eligible employees up to 12 weeks of unpaid leave during any 12-month period to care for themselves or family members during a serious health condition or for the birth or adoption of a child. FMLA requires employers to continue the group health coverage of an employee on approved FMLA leave and to restore benefits on return from that leave. For purposes of the FMLA, the health benefits provided under the Coordinating Employee Benefits Plan qualify as "group health coverage" and the FMLA therefore applies to this Pre-Tax Benefits Plan.

If you take leave under the FMLA, you have two potential options regarding your election under the Plan:

- You may revoke your existing election under the Plan for the remaining portion of the Plan Year as described under Election Changes in this document.
- You may elect to continue your participation throughout your FMLA Leave.

Your election of one of these two options must be made within 30 days of the start of your FMLA leave and you may not make or apply an election retroactively. If you do not make an election to the contrary as outlined in this document, your participation will be deemed to continue during your FMLA leave, coverage will continue during your leave, and premiums will be due as outlined below. The regular salary contributions required by your elections will be due and payable by you during your leave period, even in the case of a deemed election (where you don't act affirmatively to indicate you are revoking your elections).

If you revoke your election under Premium component of the Plan while on FMLA leave, your employee benefit coverages will cease during that time and any claims you incur will not be payable under the health benefit contracts.

Participants on FMLA leave have the same rights to change benefit elections, such as a change in family status, as do other Participants. If a change occurs while you are on leave, you will have 30 days to make the change effective.

Q-14. What are my repayment options for missed contributions during FMLA?

If you choose to continue receiving Plan benefits while on FMLA, you are responsible for paying the same premium contribution amounts you were paying as when you were an active employee. Several payment options are available to you while on FMLA leave:

- Pre-pay basis - You may pre-pay your salary reductions before beginning unpaid FMLA leave. Payments under this option may be made on a pre-tax salary reduction basis from any available compensation. These payments will not be included in gross income, provided all Plan requirements are satisfied.
- Pay-as-you-go basis - Under the pay-as-you-go option, you may make contributions to the Plan during paid or unpaid FMLA leave on the same schedule as if you were not on leave or you may make equivalent monthly contributions. If you are not receiving compensation during your leave, payments made under this option are made on an after-tax basis. If you are receiving compensation during your leave, such as salary continuation, sick leave, or vacation pay, your contributions may continue during your leave as pre-tax salary reductions.
- Catch-up contributions - You may pay by making "catch-up" contributions after returning from your FMLA leave. Catch-up contributions may be made in a lump sum upon return from your FMLA leave or may be made by adjusting your ongoing salary reductions upon return from your FMLA leave to a new level basis to make up for any missed salary reductions during your leave. These contributions are typically made on a pre-tax basis. However, if necessary, after-tax contributions may also be made for catch-up contributions.

If your FMLA leave spans two Plan Years, you may not defer compensation from one Plan Year to a subsequent one. Therefore, you can only pre-pay Plan contributions on a pre-tax basis until the end of the

Plan Year. You will be allowed to make up the amount missed while on leave in the next Plan Year, but it must be on an after-tax basis.

If "catch-up" contributions or unpaid "pay-as-you-go" contributions are due upon return from leave and you do not return to work, the catch-up contributions or unpaid pay-as-you-go contributions are due and payable. Your Employer reserves the right to take make-up salary reductions from any and all compensation payable to you as the employee, including vacation pay, sick leave or any salary continuation payments. If no compensation is available for salary reductions, you must make direct payments to Your Employer to repay the contributions due. Your Employer may consider unpaid contributions as any other debt owed to Your Employer.

If you return to work after a leave and elect to pay catch-up contributions or unpaid pay-as-you-go contributions over the remainder of the Plan Year, but later terminate employment prior to when all catch-up contributions or unpaid pay-as-you-go contributions are made, Your Employer reserves the same right to collect these unpaid contributions out of any available compensation or to collect the make-up contributions directly from you as described above.

Q-15. How does the Plan coordinate with other leaves of absence?

If you go on an unpaid leave of absence or a non-FLMA leave of absence, the personnel policies of Your Employer will govern whether you may continue to participate in the Pre-Tax Benefits Plan. Typically, if you are eligible to continue participating in other employee benefit plans, you will also be eligible to continue participating in the Pre-Tax Benefits Plan. And typically, if you are not eligible to continue other employee benefit plans, you will not be eligible to continue participating in the Pre-Tax Benefits Plan. If Your Employer's policies allow for continuation of participation while on unpaid leave, the same provisions apply as under an FMLA leave, as outlined above in this section. If Your Employer's policies indicate that you may not continue, your participation in the Plan will be terminated. You will be offered COBRA continuation coverage under the standard provisions of the law if Your Employer is subject to Federal COBRA laws. Whether you can elect to make an election change at the time you go on an unpaid leave of absence is subject to all the election change provisions outlined in this section.

Q-16. Who is an eligible dependent?

Your eligible dependents for whom pre-tax contributions may be made are those that qualify under the insurance contracts currently in force under the employee benefit plans of Your Employer. Please note that premium expenses for a domestic partner are not eligible under this Plan unless the dependent qualifies as a dependent under the IRS guidelines (IRC §152), regardless of whether they may be eligible to be covered as dependent on any health insurance contracts. This means that the value of premiums you pay for a domestic partner coverage must be taxed to you, unless that dependent is actually listed as a dependent on your tax return. Your Employer reserves the right to request documentation to substantiate domestic partner tax-dependent status.

Q-17. What happens if want to drop my insurance in the middle of the Plan Year?

The decision to elect to pay your insurance premiums pre-tax through the Plan is binding for the full Plan Year, unless you are eligible for a change allowed by the IRS as described in this section. If you discontinue your insurance coverage in the middle of the Plan Year without an allowable reason (Status Change or other Qualified Mid-Year Exception), you may be required to continue to continue to pay premiums via salary reduction regardless, even if some or all of your coverage is terminated. This provision doesn't make logical sense, but it is important to be aware that the IRS rules say even if you drop your insurance coverage, your contributions will need to continue to be paid if you drop or change your coverage for a reason that is not specifically allowed by the IRS.

Q-18. Can my Employer modify my Premium Contribution election under the Plan?

If the amount of your required premium contributions(s) increases or decreases as a result of a rate adjustment required by an independent third party (such as an insurance company) or as a result of a change in the required contribution as determined by Your Employer, Your Employer will automatically increase or decrease the amount of your premium contribution election(s).

Q-19. Can I change my Premium Contribution election under the Plan?

Generally, you make an irrevocable election for the entire Plan Year, and you may not change it during the Plan Year. You may always change your pre-tax premium election in coordination with each new Plan Year. There are some specific exceptions to the irrevocability rule regarding when you can change your election mid-year. These are outlined in detail in Section 7: Election Change Rules.

Q-20. Are COBRA premiums eligible salary reductions?

Yes, payment of COBRA premiums for group health coverage *sponsored by Your Employer* is eligible for pre-tax salary reductions under the Plan. Such premium payments must be for COBRA coverage for an employee, spouse, or eligible dependents. Salary reductions *may not* be made to pay for COBRA coverage for a divorced spouse, a domestic partner, or any other person that is not an eligible dependent under the IRS tax code and your group health coverage Plan. Salary reductions may not pay for any COBRA coverage other than coverage under the group policy sponsored by Your Employer. Additionally, salary reductions may not pay for coverage for a period of time outside of the Plan Year. COBRA premiums for coverage sponsored by any other employer are not eligible for pre-tax salary reduction under the Plan. Practically, COBRA premiums must be paid in advance of a termination event. Such a lump sum pre-payment of premiums is an acceptable exception to the requirement for substantially equal premium payments throughout the Plan Year. Although this is an eligible practice, Your Employer reserves the right to not accommodate such a request.

Q-21. Are other individual health plan premiums eligible for salary reductions?

No, premiums for any health plans that are not a group plan directly sponsored by Your Employer are not eligible for pre-tax salary reduction under the Plan. This includes any individual health policy and any COBRA premiums for coverage through any other employer.

Section 9: Health FSA Benefits

Q-1. What is a Health FSA?

You have the opportunity to elect to receive income tax-free reimbursement for some or all of your qualified out-of-pocket health expenses under the health FSA component of the Plan. Under these provisions, you elect a specific level of salary deferrals and authorize Your Employer to make salary reductions, in lieu of receiving the corresponding amount of current pay. Your salary reductions are not taxable, and, therefore, you save Social Security and income taxes on the amount of salary reductions you elect.

If you elect to reduce your income under the health FSA provisions of the Plan, a health FSA will be set up in your name to keep a record of the salary deferrals you have made during the Plan Year. Your health FSA is maintained for accounting purposes only; there is not an actual monetary account set up in your name nor are there actual deposits made to your health FSA, and interest is not accrued to your account. Your salary reductions are accounted for by Your Employer, but the actual monetary salary deferrals are maintained as a general asset of Your Employer. You may submit claims for reimbursements for up to the total amount elected in the Plan Year.

Q-2. What are the minimum and maximum amounts I can elect?

If you elect to participate in the Plan, you must make level salary reductions equal to the total annual amount elected over the course of the Plan Year. You may elect to defer any amount of salary you desire, subject to the annual Plan minimum and maximum reimbursement limitations as specified in Part 1, the PDD Fact Sheet.

Q-3. What does "Use It or Lose It" mean?

The most important Plan restriction is the "use it or lose it" rule. In short, this rule means that any unused amount in your account will be forfeited. You must carefully estimate your annual health expenses prior to your election. If you over-estimate your expenses and do not actually incur your estimated eligible health expenses by the Claim Incurred Deadline, the unused money in your health FSA will be forfeited to Your Employer. Forfeited amounts are used to offset administrative expenses, Plan losses, and overall Plan costs.

Q-4. How are my salary reductions made?

When you become a Participant, your contributions will be taken out of your gross income via pre-tax salary reductions. These salary reductions must be made in substantially equal amounts throughout the Plan Year and not in lump sum payments or unequal payments throughout the Plan Year unless there is an administrative error or other Plan provisions that justify an alternative method of unequal salary reductions.

Q-5. What happens if I elect not to participate in this Plan?

Any portion of your compensation for which you do not choose to make a salary reduction and elect to participate in the health FSA will be paid to you in full as regular, taxable compensation.

Q-6. How is my account maintained?

After you make an election, contributions to your health FSA are set up as salary reductions from your gross income each paycheck and credited to your health FSA. (Your per-paycheck contribution is calculated by dividing the total annual amount elected by the number of remaining paychecks in the Plan Year, so your salary reductions are substantially equal throughout the Plan Year.) The full amount of the coverage elected will be available for reimbursement for your eligible health expenses at any time during the Plan Year, so long as you continue your salary reductions and participate in the Plan. Reimbursements for qualified health care expenses are paid to you from general assets of Your Employer.

Q-7. When must my election be made?

If you are a newly eligible employee, you must make your election within 30 days of your initial eligibility date. For Open Enrollment, you must make your election with respect to a specific Plan Year during the Annual Open Enrollment Period immediately preceding such Plan Year (according to the procedures described by Your Employer).

The Annual Open Enrollment Period begins approximately one to three months prior to the new Plan Year. Generally, you will receive Annual Open Enrollment Election materials between October and early December prior to the new Plan Year, depending on when Your Employer has arranged the Open Enrollment period. If you do not receive these materials in a timely manner, you must request them from the Plan Administrator at least ten (10) days prior to beginning the new Plan Year.

Q-8. Do I need to make a new election each year?

Yes. Your participation in a health FSA requires a new election each Plan Year. This election may be the same or different from the previous Plan Year. However, even if it is the same, you must make a new election (according to Your Employer's enrollment procedures). Any changes will become effective on the first day of the next Plan Year. If you fail to make a new election, your election will be deemed to be zero for that Plan Year.

Q-9. Can I change my election?

Generally, no. Your health FSA election is generally deemed to be irrevocable for the plan year. That said, there are some specific circumstances when you can make a change to your election. Please refer to Section 7 of this PDD Disclosure Document for full details on the rules for changing your election.

Q-10. What are Flex Credit Dollars?

Flex Credit Dollars are amounts that Your Employer contributes on your behalf. You use your Flex Credit Dollars to pay for part or all of the benefits you elect. The amount of Flex Credit Dollars, if any, is determined

annually by Your Employer. Your Employer will communicate the Flex Credit Dollar allocation during Open Enrollment. Any Flex Credit Dollar amount may be adjusted upward or downward at Your Employer's discretion. Details of your allocation, including whether any cash out of unused Flex Credit Dollars is available, can be found on the PDD Fact Sheet and in the enrollment materials provided by Your Employer.

Q-11. What if I terminate my employment during the Plan Year?

If your employment with Your Employer is terminated during the Plan Year, your active participation in the Plan will cease. In some cases, a salary reduction may be made in your final paycheck (which may actually be after your date of termination) to reflect coverage prior to your termination date. Plan continuation and reimbursement provisions differ between the three plan components (Premium Salary Reductions, health FSA, and Dependent Care FSA) and are thus addressed in the specific descriptions for each component.

Q-12. Do I have access to my entire health FSA election?

Yes. After you have made your election, you have access to the full election as of the first day of the Plan Year or your Plan effective date, provided you continue to make your salary reductions. Your balance will be reduced by the amount of prior reimbursements received during the Plan Year. This is an important feature of the health FSA. You do not have to wait until you have contributed the full amount to receive a reimbursement. For example, Mike makes an annual health FSA election of $2,400. His election is taken out of his paycheck in 24 equal installments of $100. In February, after he has made only $300 in contributions to his account, he incurs a medical expense of $4,000. He can request reimbursement and is eligible to receive the entire $2,400 that he elected, right in February. Then, he must continue to pay the remainder of the salary reductions over the remainder of the year. If your reimbursements exceed the amount you have contributed and you then terminate your employment, you do not need to make repayment for any excess reimbursement, nor do you need to make any further contributions.

Q-13. What is the Claim Incurred Deadline?

Typically, the Claim Incurred Deadline is December 31st (the end of the Plan Year) and you should always try to incur expenses equal to your election *during* the Plan Year. However, in some cases an employer may make an election to extend the Claim Incurred Deadline to allow for claims to be incurred up to 2½ months after the end of the Plan Year so that expenses that might otherwise be forfeited might be eligible for reimbursement. This extra 2½ month period is known as the Grace Period.

There are many complex reasons (both administrative and financial) why Your Employer may or may not elect to extend the Claim Incurred Deadline. It is important to note that it may only be elected in advance on an Employer-wide basis and exceptions cannot be made for a specific participant. Please check the Claim Incurred Deadline in Part 1, the PDD Fact Sheet, to confirm the last date to incur claims under this Plan.

Q-14. How does the Rollover provision work?

Some employers choose to offer the rollover (also known as "carryover") provision under their health FSA. The rollover provision allows for up to 20% of the federal election maximum to be automatically carried over to the following Plan Year if unspent. This mitigates the impact of the use-it-or-lose-it rule as it allows a portion of your unclaimed funds to be used for expenses incurred in the following Plan Year, and thus avoid losing the money. Any remaining health FSA funds in excess of the allowed rollover amount will still be forfeited. Please refer to the PDD Fact Sheet to confirm if your Plan currently offers this rollover provision.

If your plan has the rollover provision, you must be aware that all claims will be adjudicated in the order they are received (with full documentation). Additionally, claims incurred between January 1st and March 31st of the current Plan Year will only be applied to the available balance in the current Plan Year. Only after the Claim Submission Deadline has passed will potential rollover balances be available for reimbursement for eligible claims incurred during the current Plan Year. The process of carrying forward rollover balances will happen automatically during the month of April, after the Claim Submission Deadline has passed. If you make a prospective health FSA election for the current Plan Year, then the rollover amount will be automatically added to your available account balance. If you do <u>not</u> make a health FSA election for the current Plan Year, then Vita will create a health FSA for you in the amount of the rollover balance.

The following example assumes a maximum health FSA rollover of $550 (20% of the 2020 federal maximum of $2,750) and illustrates a typical rollover situation (individual circumstances will determine if this example is applicable to you):

Prior Plan Year	
January 1st	Elected health FSA of $1,000
As of November 29th	Received eligible reimbursements of $750
December 31st	Remaining unused health FSA balance of $250

Current Plan Year	
January 1st	Elected health FSA of $1,000 for new Plan Year
January 15th	Incurred $200 vision care expense and submitted the claim
January 16th	Claim is processed. The entire $200 claim is applied against the health FSA balance available in the current Plan Year. The remaining balance for the current Plan Year is now $800. The remaining balance for the prior Plan Year is still $250.
March 31st	No further eligible expenses are incurred, submitted, or reimbursed out of either Plan Year. The remaining unused health FSA balance from the prior Plan Year is $250.
Between April 3rd and April 30th	The entire unused health FSA balance of $250 will roll over to the current Plan Year, resulting in a new available health FSA balance of $1,050 ($800 + $250).

Q-15. How does the Grace Period work?

It is important to note that if Your Employer has adopted the Grace Period and the Claim Incurred Deadline is extended to allow claims to be incurred during the 2½ months following the Plan Year (refer to the PDD Fact Sheet), you must be aware that all claims will be adjudicated in the order they are received (with full documentation). Additionally, claims will be applied to any balance in the prior Plan Year until that balance is exhausted; then, claims will be applied to any election in the current Plan Year. In certain circumstances, this may cause a problem that you must be aware of and that you may need to manage carefully in order to avoid losses. In short, the order in which claims are submitted can have a significant (and potentially negative) impact on whether and how claims submitted during the Grace Period are reimbursed.

The following example illustrates this potential situation:

Prior Plan Year	
January 1st	Elected health FSA of $1,000
As of November 29th	Received eligible reimbursements of $850
November 30th	Incurred hospital charge for $250 (but hospital doesn't process charge right away)
December 31st	End Plan Year with balance of $150

Current Plan Year	
January 1st	Elected health FSA of $1,000 for new Plan Year
January 15th	Incurred $200 vision care expense and submitted the claim
January 16th	Claim is processed. $150 is applied to the remaining prior year's balance and $50 is applied to current year's election. Prior year's balance is now $0. Current year's balance is now $950.
January 17th	Prior year $250 hospital claim paperwork is processed, and you submit the claim.
January 18th	The $250 hospital claim is denied. The $250 hospital claim will never be applied to *either* the prior Plan Year or the current Plan Year. The account balance for the

prior Plan Year was $0 at the time the claim was submitted, therefore, no reimbursement could be made. Additionally, the claim is not eligible for the current Plan Year (since it was incurred in the prior Plan Year). Had there been a balance left in the prior Plan Year, the $250 hospital expense would have been eligible, however the prior year's balance was used up by the vision care expense from the current Plan Year. If the current Plan Year election of $1,000 was to have included the $200 vision care expense, you may have a shortage in your incurred expenses for the current Plan Year and thus may be subject to a potential loss.

Q-16. Whose expenses are eligible?

Qualified health care expenses for you (as the participant), your spouse, and any of your qualified dependents are eligible for reimbursement under your health FSA. Dependents are defined under the health FSA as any individual who is your dependent as defined by the IRS (§152) or who is a child dependent who will not attain age 27 before the end of the tax year. Otherwise, eligible health expenses of a domestic partner are not eligible for reimbursement under the health FSA unless that domestic partner qualifies as a dependent on your tax returns as defined by the IRS (§152), regardless of whether they may be a covered dependent on any health insurance contracts. This means that the domestic partner must actually be listed as a dependent on your tax return. Your Employer reserves the right to request documentation to substantiate domestic partner tax-dependent status.

Qualified expenses for you and/or your eligible dependents are eligible for reimbursement *regardless* of whether you have waived off of the group sponsored health plan coverage offered by Your Employer. You do not need to elect to be covered under Your Employer's health plans in order to participate in the health FSA. If you and/or your dependents are covered by a spouse's plan, another employer sponsored plan, or an individual plan, you and your dependents' qualified, otherwise unreimbursed, expenses are eligible for reimbursement under this Plan.

The IRS will treat certain children whose parents are divorced, separated, or living apart as dependents of both parents for purposes of employer-provided accident and health coverage, deductible health expenses, qualified health expenses under HSAs, regardless of whether the custodial parent releases the claim to exemption.

Q-17. What is an "Eligible Health Expense"?

An "Eligible Health Expense" generally means any medical, dental, or vision expense which you could have claimed a medical expense deduction on an itemized, federal income tax return (without regard to any threshold limitation) AND which is eligible under the terms and conditions of this Plan. In addition, the expense must not otherwise have been reimbursed from any insurance plan. In order to be considered eligible, the service or supply must be medically necessary, that is, utilized for medical reasons only, not for general health reasons. For example, massage therapy for general well-being or cosmetic services would not be considered eligible expenses. Drugs and medicines available "Over-The-Counter" (OTC) that are used to treat an illness or injury are eligible when purchased in reasonable quantities.

Following is a partial list of common health care expenses that are generally eligible for reimbursement from your health FSA. This list should serve as a reference only. It is not a complete list of eligible expenses, nor is it an itemized approved list of expenses by the Internal Revenue Service (IRS), as determinations are made by the IRS and may vary from year to year. While this list is not exhaustive, it provides an overview of the type of expenses that may be eligible under the health FSA.

Medical Services

- Ambulance Expenses
- Birth Control Pills
- Christian Science Fees
- Coinsurance
- Copayments
- Deductibles
- Hospital Expenses
- Immunizations and Vaccinations
- Laboratory/X-ray Fees
- Rx Drug Co-payments
- Routine Physical Exams
- Sterilization Expenses
- Surgical Expenses
- UCR Excess Charges

Other Services

- Childbirth Classes
- Fertility Treatments
- Sales Tax (on Medical Items)

Dental Services

- Dental Care
- Dentures
- Orthodontia (only payments made during Plan Year)
- Dental Exams
- Occlusal Guards
- Implants

Vision Services

- Corrective Contact Lenses
- Eye Exams
- Eyeglasses (corrective)
- Laser Eye Surgery
- Prescription Sunglasses

Durable Medical Equipment

- Blood Pressure Monitoring Device
- Crutches
- Hearing Aids
- Oxygen
- Wheelchair

Therapy

- Acupuncture
- Chiropractic Care
- Physical Therapy
- Speech Therapy
- Massage Therapy*
- Psychiatry*
- Psychologist Fees*
- Drug/Alcoholism Treatment*

Over-the-Counter Products

- Allergy Medication
- Antacids
- Cold & Sinus Medication
- Canker & Cold Sore Relief
- Pain Relievers
- Wound Ointment
- Smoking Cessation Products
- Anti-Diarrheals & Laxatives
- Sleep Aids
- Medicated Lotions/Creams

** These expenses require confirmation of medical diagnosis and a statement of the medical necessity of the specific treatment.*

If you have questions on eligible expenses, please contact Vita for assistance in seeking clarification prior to making an election to participate. If you plan on having an expense reimbursed and you later find out that it is not eligible, you may not change your election. One resource for claim eligibility is the searchable database on the Vita website at help.vitacompanies.com. For additional information regarding questions on eligibility of certain expenses, contact the Vita Concierge at 650-966-1492 or 800-424-3052 or via e-mail at help@vitamail.com.

You may also consult your personal tax advisor, IRS Publication 17 "Your Federal Income Tax", or IRS Publication 502 "Medical and Dental Expenses", which identifies general principles for eligibility of medical expenses for tax deduction purposes. However, please note there are certain items that may be eligible for personal tax deduction and thus listed in Publication 502 and otherwise generally accepted as eligible expenses for a personal tax return that are NOT eligible expenses under your Vita health FSA. In some cases, guidance from the IRS on expense eligibility is vague or difficult to administer. In these circumstances, Vita has developed detailed policies on the eligibility of expenses so that they can be applied uniformly to all Plan participants. The Vita policies and procedures take into account available guidance from the IRS, but in some cases this Plan is more restrictive as to eligibility of expenses than what might be eligible for reimbursement under a personal tax return.

Vita retains full authority to make final determinations as to whether or not a claim is considered eligible for reimbursement under the guidelines of the Plan. Vita will take into account whether the expense is deemed eligible according to the IRS, whether the expense is eligible according to the Plan guidelines, and whether appropriate documentation has been provided. Please note that there are certain expenses considered eligible by the IRS (either by reference in Publication 502 or by other IRS guidance) that are specifically and purposefully excluded from this Plan due to the difficulty associated with documenting and administering reimbursement for these items.

In any circumstance where there is disagreement between the IRS guidelines (the IRS Code, IRS regulations, or phone advice provided by an IRS customer service representative), the Pre-Tax Plan Detail Document and administrative policies of Vita will prevail as the governing practice.

Note that IRC Section 125 and Publication 502 have different rules on when an expense must be incurred. To "incur" a health care expense, as defined by Section 125, means the date when the participant is provided with the care that gives rise to the health care expense, not when the participant is formally billed/charged or actually pays for the care. In some cases, the rules regarding when an expense is considered to be incurred are different for personal tax deductions. You may order a current copy of IRS Publication 502 by calling the IRS at 800-829-3676 or by visiting www.irs.gov and searching for Publication 502.

Q-18. Are over-the-counter (OTC) expenses eligible?

In an effort to provide clarity regarding how over-the-counter item expenses will be treated, Vita has identified five categories of over-the-counter items and has provided a description of how each will be treated and what documentation is required for each.

All over-the-counter expenses are also subject to an IRS rule against stockpiling. This means you may not purchase over-the-counter medicines or products in "stockpile" quantities. This generally means quantities that you will not be able to consume within the Plan Year. A product is considered "consumed" if the packaging is opened. Without a doubt, the day-to-day application of the IRS rules against stockpiling can be difficult to understand. As a general policy, Vita will approve claims for three or fewer of an item in a single purchase. However, fifteen (15) days prior to the Claim Incurred Deadline, Vita will approve claims for *one* of an item purchased. If you have questions regarding whether a certain amount of an over-the-counter item would be considered stockpiling, please contact the Vita Concierge.

Following is an overview of the five categories of over-the-counter expenses, the eligibility specifications of each type, and the documentation requirements necessary for certain types of over-the-counter expenses.

1. Products with a Drug Compound

   Any product with a drug compound that is governed by the FDA and that is specifically designed for a medical purpose is eligible. Examples of products in this category include:

   - Pain Relief Medications: Advil, Tylenol, Aleve, Aspirin
   - Cold/Flu Remedies: Theraflu, Robitussin, Tylenol Cold, Dimetapp, Benadryl, Claritin, Sudafed, cough suppressants
   - Digestive System Medications: Pepto-Bismol, Imodium, Zantac, laxatives
   - Skin/Foot Medications: Cortisone Cream, Wart Remover, Lamisil, Anti-Fungal Cream
   - First Aid Products: Neosporin, Antibiotic Cream, Benadryl Anti-Itch
   - Acne Treatments: Retin-A, Differin, Proactive

2. Products without a Drug Compound with a Single Presumed-Medical Use – *Eligible on a Product Specific Basis*

   There are many products with medical applications that do not include a drug compound (and thus are not governed by the FDA) and therefore cannot be immediately presumed to be used for medical purposes. However, if the product is generally utilized only for a single purpose which is medical in nature, the over-the-counter product may be approved as an eligible expense. If the product may potentially have a dual purpose, it cannot be approved under this category. Examples of products in this category include:

   - Wound Treatment: Band-Aids, Gauze Pads, Ace Bandages
   - Injury Treatment: Cold Packs, Joint Brace (Ankle, Knee, Finger, etc.)
   - Denture Care: Denture Adhesive
   - Contact Lens Cleaning: Contact Lens Solution
   - Diabetes Supplies: Test strips, Lancets and Tips, Glucose Monitors
   - Health Monitors: Blood Pressure Monitor, Cholesterol Monitor
   - Fertility Products: Ovulation Predictor Kits, Pregnancy Tests

3. Dual Purpose Items – Require Additional Documentation and a Physician Statement of Medical Necessity

   There are many products that may be used for medical purposes but also may potentially be used for non-medical purposes. Generally, these products are not eligible without additional documentation from a medical provider stating the medical necessity of utilizing the specific product for a medical purpose. While we understand this may be a "hassle" for plan participants, it is necessary to confirm the

medical necessity of the product usage in order to authorize it as eligible. Without a specific medical confirmation for a dual purpose over-the-counter product, the item will not be an eligible expense. Examples of products in this category include:

- Certain Lotions: Sarna Lotion
- Certain Allergy Products: Air Purifier
- Herbal Treatments: St. John's Wort, Cranberry Supplements, Garlic Pills, Ginkgo Biloba
- Medicated Shampoo: RID, Other Medicated Shampoos
- Certain Vitamin/Mineral supplements to treat medical conditions

4. Marginal Cost Items – Require Additional Documentation and Physician Statement of Medical Necessity

   Certain dual purpose items are typically utilized in the daily life of most persons as a personal care item. With certain personal care items, a medical condition may give rise to an additional cost in the purchase of the standard item. In these circumstances, the *marginal additional cost* attributable to the medically required product (as opposed to products available to the general public for everyday use) may be an eligible expense. Examples of this include orthopedic shoes, allergy-sensitive bedding products, Braille books and magazines.

   How this marginal cost is calculated is important to understand. The general public uses certain products as personal care items. Such products can range in price dramatically depending on the quality and where the product is purchased. Both an average quality product and a high-quality (more expensive product) may be available to the general public. In this circumstance, the marginal cost will be calculated based on the difference between the cost of the medically necessary product and the *average cost* of the product available to the general public. This methodology is used only when the cost of the medically necessary product is higher than the average cost of the "generally available" product.

   In many cases, this methodology eliminates or significantly reduces the marginal cost which may be an eligible expense. For any such items, Vita will determine the marginal cost based on web searches for the personal care item. The following is an example which illustrates this type of expense:

   - Medically necessary Hypoallergenic $200
   - Cost for a Basic Mattress Pad (general $100
   - Cost for a Deluxe Mattress Pad (general $180
   - *Average* Cost of a Mattress Pad (general $140
   - Eligible FSA Expense (the marginal cost) $ 60

The eligible FSA expense is the difference between the average cost of a non-medically necessary mattress pad and the actual amount paid for the mattress pad which was specific for the medical condition, which in this case is $60.

5. Personal Care/General Well-Being/Cosmetic Products – Not Eligible

   Products that are generally used for personal care, for general well-being, or for the promotion of health are not considered eligible expenses. Examples of products in this category include:

   - Personal Care Products: Toothpaste, Efferdent, Chapstick, Shampoo, Conditioner
   - Personal Hygiene Products: Shaving Cream, Razors, Q-Tips, soap, toothbrush, etc.
   - Vitamins: Centrum, Geritol, Iron Supplements, Calcium Supplements
   - Diet Enhancers: Appetite Suppressants, Diet Pills
   - Food Products: Protein shakes, Balance Bars, Body Building Products, Weight Watchers, Diet Food, etc.
   - Beauty Treatments: Face Creams, Makeup (Medicated or Otherwise), Nail Polish, Tanning Salons
   - Hair Treatments: Nair, Permanent Waves, Hair Coloring
   - Dental Treatments: Teeth Whitening Products
   - Clothing: Maternity clothes, Other special clothing products

If you have questions about the category or general eligibility of over-the-counter expenses, please contact the Vita Concierge at (650) 966-1492 or help@vitamail.com.

Q-19. Special Information on Certain Expenses

Certain claims, including but not limited to counseling, psychotherapy, massage therapy, and orthodontia require special consideration and are only eligible in certain circumstances. Following is an outline of the details of some of these types of health expenses.

Counseling or Psychotherapy	Only expenses for counseling and psychotherapy that are "medically necessary" for the treatment of an illness are eligible. The IRS guidelines indicate that in no circumstance is relationship counseling of any kind considered eligible. Therefore, marriage counseling, family counseling, or counseling for personal growth are not eligible expenses. Vita Flex Plan guidelines require confirmation of medical necessity prior to reimbursing any counseling or psychotherapy claim.
Massage Therapy	Only expenses for massage therapy which are expressly deemed "medically necessary" for the treatment of an illness or injury are eligible. A massage therapy claim must be accompanied by a medical diagnosis and must be for the treatment of an injury or illness or for the immediate alleviation of pain. Therapeutic massage purely for stress reduction or general well-being is not considered eligible.
Orthodontia Treatment	Only orthodontia expenses that are "incurred" during the Plan Year are considered eligible. In order for an orthodontia expense to be considered "incurred," a payment must be made toward an ongoing orthodontic treatment during the applicable Plan Year. Proof of payment is required before any orthodontia expenses can be approved for reimbursement.
Prescription Drugs	Prescription expenses are considered incurred on the date the drugs are dispensed by the pharmacy ("fill date"), not on the date they are picked up and/or paid for.
Travel Expenses	Travel expenses, including but not limited to parking fees, gas, mileage, airfare and lodging, are not eligible expenses for reimbursement under your health FSA. (Please note that although some transportation expenses may be eligible for personal tax deduction under the IRS code Section 213 in certain limited circumstances, such expenses are expressly not eligible under this Plan.)
Gym Membership Fees	Gym or fitness club membership fees are generally not eligible for reimbursement unless the membership is recommended by a medical provider to treat a specific medical condition and the commencement of the gym membership occurred *after* the recommendation by the medical provider. Fees paid to a personal fitness trainer to treat a specific medical condition will be reimbursable if a physician has indicated that these services are medically necessary to treat the specific medical condition.
Weight Loss Programs	Only expenses for a weight loss program which is prescribed by a physician to treat an existing medical condition would be reimbursable. A diagnosis code would need to be present in order to denote medical necessity. Ancillary expenses for the program, such as food, are not eligible.
Food Expenses	Food expenses of any kind are not eligible expenses for reimbursement under this Plan. This includes medically necessary food items and/or special foods that are required as part of a special diet of any kind, regardless of whether the special food item or food plan is prescribed by a physician as part of a treatment for a medical condition. (Please note that although some food items may be eligible for personal tax deduction under the IRS code Section 213 in certain limited circumstances, such expenses are expressly not eligible under this Plan.
Capital Expenses	Capital expenses, including but not limited to special equipment for a car or modifications/additions to a home, home improvements, lead-based paint removal, or other capital expenses are not eligible expenses for reimbursement under your health FSA. (Please note that although some capital expenses may be eligible for personal tax deduction under the IRS code Section 213 in certain limited circumstances, such expenses are expressly not eligible under this Plan.)

Q-20. Which health FSA expenses are not eligible?

The IRS has provided specific guidelines for expenses that may not be reimbursed on a pre-tax basis. Certain health expenses are not considered qualified and thus are not eligible for reimbursement, *even if they are prescribed by a physician.* Health expenses are not eligible if they are not directly for medical purposes or not deemed medically necessary. All eligible expenses require a medical diagnosis and must not be for cosmetic purposes. The following is a partial listing of common health expenses that are *not eligible* for reimbursement. This list is not exhaustive but provides an overview of the type of expenses that are *not eligible* under your health FSA.

Over-the-Counter Items

- Anti-Aging Products
- Beauty Products
- Bottled Water
- Cosmetics
- Dental Floss
- Diapers
- Food (any type for any reason)
- Sexual Enhancers
- Toiletries
- Toothpaste or Toothbrush
- Vitamins
- OTC Products used for general health or well-being
- Any OTC Products purchased in stockpile quantities

Personal Care/Well Being

- Childrearing classes or services
- Counseling for Relationship or Personal Growth
- Custodial Care
- Domestic Help Expenses
- Food Expenses (even if part of a weight loss program)
- Massage Therapy for general health or relaxation
- Nursing Care for home care of healthy newborn
- Psychotherapy for Relationship or Personal Growth
- Social Activities or Programs

Dental Services

- Cosmetic Dentistry
- Orthodontia payment made outside of the Plan Year

Other Services

- Funeral or Burial Expenses
- Health Insurance Premiums
- Long Term Care Expenses
- Long Term Care Premiums
- Marijuana or Illegal Substances
- Maternity Clothes
- Parking Fees
- Commute Expenses
- Weight Loss Programs
- Concierge Fees

Please note your premium contributions for your employer-sponsored employee benefit plans may be paid on a pre-tax basis under the Premium Contribution component of this Plan. Premium contributions are not eligible for reimbursement under the health FSA component of this Plan. Additionally, other individual or COBRA health plan premiums are never eligible under the health FSA component of the Plan.

Certain expenses may be considered eligible under the IRS code (for a tax deduction on your personal income tax returns outlined in IRS Publication 502) but are not eligible under this Plan. This is typically due to documentation requirements that are outside the scope of Plan administration. Such expenses include, but are not limited to, transportation costs, mileage reimbursement expenses, and food of any type.

There are many expenses that may not be listed on either of the lists of eligible or not eligible expenses. For more detailed information regarding eligible expenses, ineligible expenses, and documentation requirements, please visit the Vita website at help.vitacompanies.com or contact the Vita Concierge at (650) 966-1492 or help@vitamail.com. If you have questions about whether a health expense is eligible, please seek clarification prior to making an election to participate. If you submit an expense and you later find out that it is not eligible, you may not change your election.

Q-21. What documentation is required for a claim?

The IRS specifically requires third-party substantiation to document all eligible expenses. Expenses that do not have complete documentation cannot be reimbursed. Do not include any expenses that cannot be appropriately documented in your estimated reimbursement calculation for the year, as they cannot be reimbursed.

For health expense claims, appropriate documentation would include an insurance company Explanation of Benefits (EOB) statement, medical supply bills, co-payment receipts, provider billing or any other

documentation from an independent third party which confirms that the expenses were incurred and identifies the elements necessary for a claim. The necessary elements for a valid claim include the following:

- Patient's name
- Provider's name
- Dates of service
- Type/Description of service
- Amount charged for the expense
- Amount, if any, covered by insurance

For prescription expenses, a copy of the Rx printout provided by the pharmacy (including the name of the drug being dispensed) is required. A cash register receipt or credit card receipt is not sufficient. For over-the-counter drugs, medicines and items, a copy of a cash register or similar receipt that itemizes the individual product and associated expense will be required.

Reimbursement of certain health expenses (such as psychotherapy and massage therapy) also requires confirmation of medical diagnosis code or a statement of the medical necessity of the treatment by the provider.

All orthodontia claims require proof of payment prior to approval. Please refer to the "Special Information on Certain Expenses" question above for additional information regarding orthodontia reimbursement.

When medical necessity must be confirmed, claims must be accompanied by additional documentation. Additionally, anytime a provider billing statement or other non-EOB documentation is utilized, a copy of the EOB from the medical or dental insurance carrier(s) must also be provided, unless specific insurance reimbursement information is discernible from the detailed billing statement. This is required in order to confirm the portion of the claim that has already been reimbursed (or denied reimbursement) by any insurance plan.

Copies of cancelled checks, credit card receipts, cash register receipts (except for contact lens solution and OTC drugs and medicines), or any receipt without complete documentation outlined above alone are not considered sufficient documentation. Additionally, balance forward billing statements that do not outline the services provided and specific dates of service are also considered insufficient documentation.

Vita has the authority to request and require any and all documentation it deems necessary to substantiate the eligibility of claims prior to reimbursement. Vita retains full authority to confirm whether a claim is deemed eligible according to the IRS and the Plan and whether appropriate documentation has been provided. Final authority to accept or deny a claim based on sufficiency of the documentation provided rests with Vita.

Q-22. How are claims submitted?

If you elect to participate in the health FSA, you must take certain steps to be reimbursed for your eligible health expenses. When you incur an eligible expense, you must submit a claim to Vita for processing. All claims must include a completed Claim Form along with full and complete documentation of the expense incurred. Claim submission documents must have a signature or electronic signature equivalent. There are five (5) possible ways that claims can be paid from your account:

1. U.S. Mail. Submit a paper claim form along with claim documentation via U.S. Mail – Vita Flex, 1451 Grant Road #200, Mountain View, CA 94040.
2. Fax. Fax a completed claim form along with claim documentation to 650-961-2285.
3. Online. Complete an online claim form (available at help.vitacompanies.com) and upload claim documentation.
4. Mobile App. Download the Vita Flex mobile application, complete the online claim form, and upload claim documentation (either PDF documents or JPG pictures of claim documentation).
5. Debit Card. Use your debit card to pay for health expenses out of your health FSA account. (See rules about card usage and required documentation in this section).

Q-23. Will I have to disclose private or Protected Health Information (PHI)?

It is important to understand that in order to receive reimbursement under this Plan, you must provide documentation of your health care expenses to Vita. Some of the required documentation may be of a personal nature and you may consider it private. Indeed, some may be Protected Health Information as defined under HIPAA and thus subject to the HIPAA Privacy and Security rules. If you do not wish to disclose such information to Vita, your claims may not be eligible for reimbursement. You should carefully consider this requirement prior to electing to participate.

Q-24. How do I receive reimbursements?

After your claim is processed, you will receive a notification of processing via e-mail. You may then log on to the http://www.vitaflex.net/ website to confirm the status of your claim and your reimbursement. There are three (3) possible ways that claims can be paid from your account:

1. Direct Deposit. If you provide your banking information, reimbursements will be deposited directly into your bank account. Deposits are processed weekly.
2. Check. If you do not provide your banking information or you elect check reimbursement (not available with some employers), you will receive a check reimbursement mailed to your home. Checks are processed and mailed weekly.
3. Debit Card. If you use your debit card, you are effectively taking money out of your health FSA up front, rather than getting reimbursed after the fact. Note that in some circumstances, documentation will be requested and is required. Please remember to retain sufficient documentation as described above for ALL debit card expenses.

Q-25. What happens if I receive erroneous or excess reimbursements?

If it is determined that you have received payments under the Plan that exceed the amount of eligible expenses that have been properly substantiated during the Plan Year set forth in this document, or reimbursements have been made in error (e.g., reimbursements were made for expenses incurred for the care of an individual who was not a qualifying dependent), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways: (1) Vita or Your Employer will notify you of any such excess amount, and you will be required to repay the excess amount to Your Employer immediately after receipt of such notification. (2) Vita may offset the excess reimbursement against any other eligible expenses submitted for reimbursement (in accordance with applicable law) or (3) Your Employer may withhold such amounts from your pay (to the extent permitted under applicable law). If the excess reimbursement could not be recouped, this could result in adverse income tax consequences for you.

Q-26. When must the eligible Health expenses be incurred?

Eligible Health expenses should be incurred during the Plan Year that you have elected to participate in the Plan. The deadline for incurring eligible Health expenses is identified as the Claim Incurred Deadline in Part 1, the PDD Fact Sheet.

Additionally, eligible expenses must be incurred after your initial eligibility date if you are a new hire and after you have signed the election form. Expenses incurred prior to the beginning of the Plan Year, prior to your initial effective date, prior to the date that you signed the election form, or after the end of the Plan Year are not eligible. To "incur" an expense means the date when you or your eligible dependent is provided with the care that gives rise to the expense, not when you or your dependent are formally billed/charged or actually pay for the care.

If your employment terminates, you may be reimbursed only for expenses incurred on or prior to your termination date. If you elect to continue your health FSA under COBRA, the eligibility date for incurring expenses may be extended to the end of the Plan Year. If you do not elect to continue your coverage under COBRA, you may not be reimbursed for any expenses incurred after your date of employment termination.

Q-27. How does the debit card work?

The IRS allows the debit card to be used in three (3) primary ways:

1. At a health care provider or pharmacy for a specific copay that matches a copayment amount pre-loaded onto your card.
2. At a health care provider for a non-copay matching amount.
3. At participating pharmacies, grocery stores, wholesale stores, etc. that have installed special software for Flexible Spending Account (FSA) debit cards. This specific software recognizes eligible medical FSA items at the point of sale.

The card may only be used at health care provider offices whose merchant code reflects that of a qualified health care provider.

Q-28. What documentation is required when using the debit card?

There are two situations when documentation is typically not needed:

1. When you use your card at a qualified health care provider or pharmacy for an amount that perfectly matches the pre-loaded copay amounts under your health plan.
2. When you purchase FSA eligible items that are pre-approved for point of sale at an approved merchant.

However, in essentially all other situations, you will need to provide receipts to Vita to validate that the expense is eligible under the Plan. If you swipe your card at, for example, a medical provider office, you will receive correspondence from Vita Flex requesting that you submit documentation of the expense (that you have prepaid from your health FSA). You MUST submit documentation for the expense when it is requested. If documentation is required, and you do not present it, the expense will be presumed to be NOT eligible under the plan and you will need to repay the money (that was pre-taken from your account by swiping your card) back into your health FSA. Remember to retain documentation for ALL expenses for which you used your debit card.

Q-29. Why did my debit card get turned off?

When you do not submit requested documentation in a timely manner, your debit card will be turned off and you will not be able to use your debit card until you have provided the necessary documentation or repaid the money (if no documentation is available) to the Plan.

Q-30. How are debit card repayments made?

When you do not submit necessary documentation after using your debit card to take money from your health FSA, you are required to repay the money to the Plan. If you do not have proper documentation or have lost the documentation, you have three options:

1. You may repay the Plan directly.
2. You may provide alternate receipt documentation for at least the amount of the undocumented purchase.
3. Your Employer may take the money owed to the Plan directly out of your future compensation. If this is the case, Your Employer is not required to advise you of the specific timing of when this repayment will come out of your compensation.

Q-31. What is the deadline for submitting claims?

You will have until the Claim Submission Deadline identified in the PDD Fact Sheet to submit claims for eligible health expenses incurred during the previous Plan Year. All claims must be submitted by the Claim Submission Deadline to be considered for reimbursement. Claims received after the Claim Submission Deadline are not eligible for reimbursement. Additionally, any claims received prior to the Claim Submission Deadline without complete documentation and/or where complete documentation is not submitted by the Claim Submission Deadline are not eligible for reimbursement regardless of whether or not you are active or terminated.

If the Plan is terminated or there is a change in Contractor for Administrative Services prior to the end of the Plan Year for any reason, participants must submit any claims incurred prior to the termination date or date of change in Contractor for Administrative Services along with complete documentation by the date specified at the time of termination. If Your Employer goes out of business, Claim Submission Deadlines may be significantly shortened and you may not be able to receive any reimbursement, despite having made contributions to your account.

Q-32. What happens if a claim for benefits is denied?

If a claim for benefits is denied, you have a right to appeal the denial. An outline of the information necessary, the requirements, and the timeline for appealing a denied claim can be found under Section 17: Claims and Appeals Procedures. The claim procedures for health reimbursement claims fall under the "Post Service Claim" review rules as established by Department of Labor regulations.

Q-33. What if I am currently participating in an HSA plan?

In general, if you are currently participating in a qualifying medical plan and are either making contributions to a Health Savings Account (HSA) or having contributions made to a Health Savings Account on your behalf, then participation in the health FSA component of this Plan will disqualify you from making contributions to your HSA plan. However, you may specifically elect that your health FSA be designated as a Limited Purpose health FSA. A Limited Purpose health FSA restricts eligibility to those expenses that will not disqualify you from making contributions under your HSA. Under a Limited Purpose health FSA, only dental, vision, orthodontia, and post-statutory deductible expenses are eligible for reimbursement. Post-statutory deductible expenses are regular medical expenses that are incurred after the date in the Plan Year in which the federal statutory deductible (as set forth by IRC § 223) is met. This means that regular medical expenses will not be eligible for reimbursement until after the statutory minimum annual high deductible has been met. For post-statutory deductible expenses, you must submit documentation clarifying the specific date in the Plan Year that the amount of the statutory deductible has been satisfied prior to any such expenses being eligible for reimbursement. In some cases, the deductible on your health plan will be greater than the statutory deductible. This means that the portion of your health plan deductible that exceeds the statutory deductible will be eligible for reimbursement under your Limited Purpose health FSA.

Please note that any contribution into an HSA account may be restricted based on whether Your Employer has elected the Grace Period provision and thus extended your Claim Incurred Deadline of this plan. If the Claim Incurred Deadline crosses a Plan Year, then your eligibility to contribute to an HSA account may be limited. Please consult your tax advisor for additional information.

Q-34. How do I elect a Limited Purpose health FSA?

You may elect to have this Plan treated as a Limited Purpose health FSA, wherein only dental expenses, vision expenses, and post-deductible medical expenses will be eligible for reimbursement. You must make an affirmative election for the Limited Purpose health FSA. This election may be made via a formal election or by notifying Vita of your participation in an HSA plan and of your desire to make a Limited Purpose Account election. This notification will invoke self-imposed restrictions in this Plan which limits eligible expenses to only those defined under a Limited Purpose health FSA. Vita is not responsible for reimbursements made under the health FSA that would otherwise disqualify the Plan participant under an HSA plan for a period of time prior to the election of a Limited Purpose health FSA or if an erroneous notification was made. The election of a Limited Purpose health FSA is made at a participant level and is voluntary. The election must be made prospectively (prior to claim submissions) on an annual basis, for the entire Plan Year.

If you are contributing to an HSA plan and you submit medical expenses and do not notify Vita of your election of a Limited Purpose Account, the reimbursements could disqualify your HSA. It is not the responsibility of Vita to know whether or not you are contributing to an HSA account and thus are not eligible to submit claims under the Plan without disqualifying yourself. Regardless of whether contributions to your HSA account are made by you or are made on your behalf through Your Employer, you are responsible for notifying Vita if you wish to elect under the Limited Account provisions of this Plan.

Please note, if you become eligible under a qualifying High Deductible Health Plan mid-Plan Year and would like to start contributing to an HSA plan mid-year, you will typically be restricted from doing so because becoming newly eligible under an HDHP plan and wanting to commence HSA contributions does not qualify as a valid reason to make an election change. This extends to the fact that you may not make a mid-year change to your regular health FSA account to change it to a Limited Purpose HSA on a mid-year basis.

Q-35. How do Employer matching contributions work?

Your Employer may elect to provide a seed contribution or to match your annual election. Any such seed contribution or matching contribution is entirely discretionary and is subject to change annually at the beginning of each Plan Year. Any such Employer seed or matching contribution will be applied on a non-discriminatory basis. If such an additional Employer contribution is provided, the entire amount of the seed or matching contribution is available for reimbursement at the time you make your election. However, if you do not incur expenses during the Plan Year that exceed your combined salary reductions and Your Employer's seed or matching contributions, your salary reductions are utilized first, and the employer match is utilized second for reimbursement purposes.

The amount of Employer match, if any, is indicated in the PDD Fact Sheet of this document. The maximum election indicated in the Fact Sheet reflects your annual election (the amount of your personal salary reductions), not the combined potential account value if Your Employer provides a seed or matched contribution.

Q-36. How does the Plan coordinate with the Family and Medical Leave Act?

In general, under the Family and Medical Leave Act of 1993 (FMLA), employers with 50 or more employees are required to offer eligible employees up to 12 weeks of unpaid leave during any 12-month period to care for themselves or family members during a serious health condition or for the birth or adoption of a child. FMLA requires employers to continue the group health coverage of an employee on approved FMLA leave and to restore benefits on return from that leave. For purposes of the FMLA, the health FSA component of this Plan qualifies as "group health coverage" and the FMLA therefore applies to this Flexible Benefits Plan.

If you take leave under the FMLA, you have two potential options regarding your election under the plan:

- You may revoke your existing election under the Plan for the remaining portion of the Plan Year as described in Section 7: Election Change Rules.
- You may elect to continue your participation throughout your FMLA Leave.

Your election of one of these two options must be made within 30 days of the start of your FMLA leave and you may not make or apply an election retroactively. If you do not make an election to the contrary as

outlined in this document, your participation will be deemed to continue during your FMLA leave, coverage will continue during your leave, and premiums will be due as outlined below.

If you revoke your election under the Plan while on FMLA leave, claims incurred between the start date of your FMLA leave and when you return from your leave will not be eligible and thus cannot be reimbursed. If you elect to revoke your election before you go out on leave, you will have the option to reinstate your participation once you return to work. You will have two choices for reinstatement. You can either elect to reinstate your election at the level in effect before the FMLA leave and repay the missed salary reductions, or you can resume coverage at a level that is reduced and resume contributions at the level in effect before the FMLA leave without repaying missed contributions. Examples are provided below. Please note that in either situation, claims incurred during the revocation period are not eligible and, in both cases, the coverage level is reduced by prior reimbursements. You will have 30 days to reinstate your coverage from the date that you return to work.

- Reinstate coverage at the level in effect before FMLA. Linda has elected $1,200 under the health FSA and goes out on FMLA leave for three months, revoking her election with the start of her leave. During the three months that she is on FMLA leave, she misses a total of $300 in salary reductions. When she returns to work, she elects to increase her election to a $1,500 annual election amount. She will then be responsible for repaying the $300 that was missed while on FMLA leave and increasing her remaining contributions to reflect the increased annual election. She can then use the full $1,500 annual election for claims incurred before or after her leave of absence.
- Reinstate at a reduced level. Mary has a $1,200 health FSA election with a per paycheck reduction of $50 and goes out on FMLA for three months, revoking her election with the start of her leave. Again, she misses $300 worth of salary reductions while on FMLA leave. When she returns to work, she decides to reinstate coverage at the prorated/reduced amount of $900 and she resumes the prior salary reduction level of $50 per paycheck. Mary does not have to pay back the $300 in salary reductions that she missed while on FMLA leave, but she will only be able to claim up to $900 in reimbursement for claims incurred before or after her leave of absence.

If you do not expressly revoke your election, the default assumption is that your health FSA your coverage will continue under the Plan while on FMLA leave. Claims incurred between the start date of your FMLA leave and when you return from your leave will be eligible. However, you will be responsible for paying for ongoing health FSA contributions or repaying all missed contributions (as outlined in the question below). If your leave crosses plan years, you will still be responsible for repaying your contributions, however, you will NOT be able to repay the contributions on a pre-tax basis. Any missed contributions not repaid within the plan year must be repaid with after tax dollars.

Participants on FMLA leave have the same rights to change benefit elections, such as a change in family status, as do other Participants. If a change occurs while you are on leave, you will have 30 days to make the change effective.

Q-37. What are options for missed salary reductions during FMLA?

If you choose to continue receiving Plan benefits while on FMLA, you are responsible for paying the same premium contribution amounts you were paying when you were an active employee. Several payment options are available to you while on FMLA leave:

- Pre-pay basis. You may pre-pay your salary reductions before beginning unpaid FMLA leave. Payments under this option may be made on a pre-tax salary reduction basis from any available compensation. These payments will not be included in gross income, provided all Plan requirements are satisfied.
- Pay-as-you-go basis. Under the pay-as-you-go option, you may make contributions to the Plan during paid or unpaid FMLA leave on the same schedule as if you were not on leave, or you may make equivalent monthly contributions. If you are not receiving compensation during your leave, payments made under this option are made on an after-tax basis. If you are receiving compensation during your leave, such as salary continuation, sick leave, or vacation pay, your contributions may continue during your leave as pre-tax salary reductions.

- Catch-up contributions. You may pay by making "catch-up" contributions after returning from your FMLA leave. Catch-up contributions may be made in a lump sum upon return from your FMLA leave or may be made by adjusting your ongoing salary reductions upon return from your FMLA leave to a new level basis to make up for any missed salary reductions during your leave. These contributions are typically made on a pre-tax basis. However, if necessary, after-tax contributions may also be made for catch-up contributions.

If your FMLA leave spans two Plan Years, you may not defer compensation from one Plan Year to a subsequent one. Therefore, you can only pre-pay Plan contributions on a pre-tax basis until the end of the first Plan Year. You will be required to make up the amount missed while on leave, however, if it does not occur until the next Plan Year, the repayments will be made on an after-tax basis.

Your rights under the health FSA Plan remain the same as outlined above during the FMLA leave, assuming you elect to continue coverage under the Plan. In the case when you elect to continue coverage during the FMLA leave, claims incurred during the leave may be considered eligible and reimbursements of these claims may be made. There will be no interruption in claims eligibility, regardless of the method of premium payment elected.

Reinstatement to the health FSA Plan cannot be retroactive. As with other Plan benefits, you may elect to be reinstated in the health FSA upon return from FMLA leave, as long as your request is received within 30 days of your return from leave.

If "catch-up" contributions or unpaid "pay-as-you-go" contributions are due upon return from leave and you do not return to work, the catch-up contributions or unpaid pay-as-you-go contributions are due and payable. Your Employer reserves the right to take make-up salary reductions from any and all compensation payable to you, including vacation pay, sick leave or any salary continuation payments. If no compensation is available for salary reductions, you must make direct payments to Your Employer to repay the contributions due. Your Employer may consider unpaid contributions as any other debt owed to Your Employer.

If you return to work after a leave and elect to pay catch-up contributions or unpaid pay-as-you-go contributions over the remainder of the Plan Year, but later terminate employment prior to when all catch-up contributions or unpaid pay-as-you-go contributions are made, Your Employer reserves the same right to collect these unpaid contributions out of any available compensation or to collect the make-up contributions directly from you as described above.

Q-38. How does the Plan coordinate with an unpaid leave of absence?

If you go on an unpaid leave of absence, the personnel policies of Your Employer will govern whether you may continue to participate in the Pre-Tax Benefits Plan. Typically, if you are eligible to continue participating in other employee benefit plans, you will also be eligible to continue participating in the Pre-Tax Benefits Plan. And typically, if you are not eligible to continue other employee benefit plans, you will not be eligible to continue participating in the Pre-Tax Benefits Plan. If Your Employer's policies allow for continuation of participation while on unpaid leave, the same provisions apply as under an FMLA leave, as outlined above. If Your Employer's policies indicate that you may not continue, your participation in the Plan will be terminated. You will be offered COBRA continuation coverage under the standard provisions of the law if Your Employer is subject to Federal COBRA laws. Whether you can elect to make an election change at the time you go on an unpaid leave of absence is subject to all the election change provisions outlined in Section 7: Election Change Rules.

Q-39. What is Federal COBRA Continuation Coverage and how does it work?

COBRA is a federal law that requires employers to offer continuation coverage to employees who lose health coverage in certain circumstances. Generally, the law applies to employers with more than 20 employees. COBRA Continuation Coverage means you and/or your spouse and dependents have the right to continue coverage under any of the component health benefit plans if coverage (for you, your spouse, or your dependents) otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is any of the following events:

- Termination of your employment (for a reason other than gross misconduct)
- Reduction of your work hours (which causes a loss of health coverage)
- Death

- Divorce or legal separation from your spouse
- Your child is no longer eligible to remain enrolled on the plan due to age.

For a Qualifying Event, other than a change in your employment status, it is your responsibility to inform Your Employer in writing of the Qualifying Event within 60 days of the occurrence. After a Qualifying Event occurs you, your spouse, or your dependents (if covered) will receive a formal COBRA election notification as required by law. This notification will provide information about continuation rights and costs as well as the terms and conditions for continued coverage.

COBRA Continuation Coverage under this Plan is only available with respect to a health FSA, not a Dependent Care FSA, and in most cases COBRA coverage under your health FSA may only be continued through the end of the current Plan Year in which the Qualifying Event occurred. Please note that if you have received reimbursements from your health FSA that exceed your year-to-date pre-tax contributions to the Plan, then you are not eligible to continue your health FSA under COBRA. In this circumstance, the amount of your health FSA benefit remaining for the current Plan Year would be less than the amount you would be required to pay in COBRA premiums to continue your health FSA.

If you elect to extend participation in the health FSA through Federal COBRA, you will effectively extend your employment termination date for the purposes of determining when claims are considered eligible. Eligible claims incurred while you are continuing your coverage under COBRA are eligible for reimbursement. If you do not elect to extend your health FSA through Federal COBRA for this Plan, health reimbursement claims incurred after your employment termination date are not eligible. After the end of the Plan Year, you may not continue COBRA coverage under your health FSA or re-elect coverage under a subsequent Plan Year.

If you have a health FSA Rollover from the prior Plan Year, you may be eligible for COBRA continuation for that "Rollover only" health FSA, even if you did not make a health FSA election in the current Plan Year. Eligibility to access the Rollover funds after your termination date is contingent upon your FSA plan provisions, being an active employee on "day one" of the current Plan Year, and affirmatively making an election to continue your Rollover FSA under COBRA (no default elections will be made). Rollover funds are available only through the end of the current Plan Year and may not be further rolled over to a future Plan Year.

If you also made an active health FSA election for the Plan Year in which you terminated, you must elect to continue that election under COBRA in order to have access to your Rollover funds past your termination date. The Rollover FSA cannot be continued separately from your active election.

Upon a COBRA Qualifying Event of termination of employment or reduction in hours, you will receive a COBRA election notice that includes detailed information about your COBRA rights and responsibilities. You may need to contact the COBRA administrator to confirm whether your health FSA plan is eligible for continuation.

Q-40. What is a "Qualified Reservist Distribution (or QRD)"?

The Heroes Earnings Assistance and Relief Tax Act of 2008 (or HEART Act) allows reservists to receive all or a portion of their health FSA account balance if they are called to active duty for 180 days or more. This distribution may be made any time from the date of the call of duty through the Claim Submission Deadline for the Plan Year in which the call occurred. The taxable distribution will be equal to the amount reduced from your salary, less any reimbursement amounts. The request for the distribution must come in the form of a written request within 60 days of the active call to duty date. Please contact Your Employer for details as to whether or not Your Employer adopted this Plan option. If it is determined that you have received a Qualified Reservist Distribution for the applicable Plan Year in excess of the amount allowed by the provision above, Vita shall give you written notice of any such excess amount, and you shall repay such excess to Your Employer within sixty (60) days of receipt of such notification.

Section 10: Dependent Care FSA Benefits

Q-1. What is a Dependent Care FSA?

You may elect to receive tax-free reimbursement for some or all your work-related dependent care expenses under the Dependent Care FSA component of the Plan. Under these provisions, you make pre-tax salary reductions which then provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses. You elect a specific level of salary deferrals and authorize Your Employer to make salary reductions, in lieu of receiving the corresponding amount of current pay. Your salary reductions are not taxable; therefore, you save Social Security taxes and certain income taxes on the amount of salary reductions you elect.

If you elect to reduce your income under the Dependent Care FSA provisions of the Plan, a Dependent Care FSA will be set up in your name to keep a record of the salary deferrals you have made during the Plan Year. Your Dependent Care FSA is maintained for accounting purposes only; there is not an actual monetary account set up in your name, nor are there actual deposits in the account, and interest does not accrue to your account. Your salary reductions are accounted for by Your Employer, but the actual monetary salary deferrals are maintained as a general asset of Your Employer. You may submit claims for reimbursement for up to the total amount of salary reductions you have contributed to date in the Plan Year. (Note, unlike the health FSA, the Dependent Care FSA is a pay-as-you-go plan.)

Q-2. What is the minimum benefit I can elect?

If you elect to participate in the Plan, you must make level salary reductions equal to the total annual amount elected over the course of the Plan Year. You may elect to defer any amount of salary you desire, subject to the minimum specified by the Plan. The minimum deferral amount is specified in the PDD Fact Sheet.

Q-3. What is the maximum benefit I can elect?

The maximum benefit under the Dependent Care FSA component is prescribed at the federal level. If you elect to participate in the Plan, you must make level salary reductions equal to the total annual amount elected over the course of the Plan Year. Near the end of each calendar year, the IRS announces the Federal Maximum annual election amount that will apply to the following calendar year. You may elect to defer any amount, subject to the maximum amounts outlined below.

Status	Annual Maximum
Single or a Head of Household for tax purposes	Federal Maximum
Married, filing a joint return	Federal Maximum
Married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free Dependent Care FSA reimbursements, or your Spouse maintains a separate residence for the last 6 months of the calendar year, and you file a separate tax return	Federal Maximum
Married, residing together but file a separate federal income tax return	One-half of Federal Maximum

In no event may your election exceed your taxable compensation (before your salary reduction under the Plan). Additionally, if you are married, your election may not exceed your spouse's actual or deemed Earned Income. Your spouse will be deemed to have Earned Income of $250 ($500 if you have two or more dependents), for each month in which your spouse is either a full-time student or incapable of caring for himself or herself.

The maximum benefits outlined above refer to the Federal Maximums for each tax year, regardless of the number of employers you may have had during the year. If you participate in another employer's Dependent Care FSA during the same calendar year, it is your responsibility to ensure that the combined Federal Maximums are not exceeded.

A spouse is deemed to be gainfully employed in situations where for any month he or she is a full-time student or is mentally or physically incapable of self-care and is living with you, as the employee, for the entire year. If a spouse is in one of these two situations, they would have deemed earned income of $250 per month for one qualifying dependent and $500 per month for two or more qualifying dependents. Please contact Vita for more details regarding the criteria for being a "full-time student".

Q-4. What are the enrollment periods for entering the Plan?

The annual Open Enrollment period begins approximately one to three months prior to the new Plan Year. Generally, you will receive Open Enrollment election materials between October and early December prior to the new Plan Year, depending on when Your Employer has arranged the Open Enrollment period. If you do not receive these materials in a timely manner, you must request them from Your Employer at least ten (10) days prior to beginning the new Plan Year.

Q-5. How are my salary reductions made?

When you become a Participant, your contributions will be taken out of your gross income via pre-tax salary reductions. These salary reductions must be made in substantially equal amounts throughout the Plan Year and not in lump sum payments or unequal payments throughout the Plan Year unless there is an administrative error or other Plan provisions that justify an alternative method of unequal salary reductions.

Q-6. How is my account maintained?

During the election process, you specify the amount of dependent care reimbursement you wish to elect for the Plan Year. During the Plan Year, contributions to your Dependent Care FSA are set up as salary reductions from your gross income each paycheck and credited to your Dependent Care FSA. (Your per-paycheck contribution is calculated by dividing the total annual amount elected by the number of pay periods remaining, so your salary reductions are equal throughout the Plan Year.) You are eligible for reimbursements up to an amount equal to your dependent care account balance at the time of your reimbursement request. You may never receive reimbursement in excess of your year-to-date contributions. Reimbursements are made from Your Employer's general assets.

For example, if you elect to contribute $4,200 per year to your Dependent Care FSA, and you are paid twice per month, your Account would be credited with $175 per pay period throughout the Plan Year. You would be eligible to receive reimbursements up to the cumulative amount contributed at the close of each pay period.

Q-7. What does "Use It or Lose It" mean?

The most important Plan restriction is the "use it or lose it" rule. You must carefully estimate your annual dependent care expenses *prior* to your election. If you over-estimate your expenses and do not actually incur your estimated eligible dependent care expenses by the Claim Incurred Deadline, your unused salary reduction contributions will be forfeited to Your Employer at the end of the Plan Year. Forfeited amounts are used to offset administrative expenses, Plan losses, and overall Plan costs. Unlike some health FSAs, there is no "rollover" provision allowed for a Dependent Care FSA.

Q-8. Can I change my election?

Generally, no. Your Dependent Care FSA election is generally deemed to be irrevocable for the plan year. However, there are some specific circumstances when you can make a change to your election. Please refer to Section 7 of this PDD Disclosure Document for full details on the rules for changing your election.

Q-9. What is the Claim Incurred Deadline?

Typically, the Claim Incurred Deadline is December 31st (the end of the Plan Year) and you should always try to incur expenses equal to your election *during* the Plan Year. However, in some cases, an employer may opt to extend the Claim Incurred Deadline to allow for claims to be incurred up to 2½ months after the end of the Plan Year, so expenses that might otherwise be forfeited might be eligible for reimbursement. This is referred to as the Grace Period provision.

There are many complex reasons (both administrative and financial) why Your Employer may or may not elect to extend the Claim Incurred Deadline. It is important to note that it may only be elected in advance on an employer-wide basis and exceptions cannot be made for a specific participant. Please check the Claim Incurred Deadline in Part 1, the PDD Fact Sheet to confirm the last date to incur claims under this Plan.

It is important to note that if your Claim Incurred Deadline is extended to allow claims to be incurred during the 2½ month Grace Period following the end of the Plan Year (refer to PDD Fact Sheet), you must be aware that all claims will be adjudicated in the order they are received with full documentation. Claims will be applied to any balance in the prior Plan Year until that balance is exhausted; then, claims will be applied to any election in the current Plan Year. In certain circumstances, this may cause a problem that you must be aware of and that you may need to manage carefully in order to avoid losses.

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

If you elect to participate in this Plan, you will have to take certain steps to be reimbursed for your eligible dependent care expenses. When you incur an expense that is eligible for reimbursement, you must submit a claim to Vita on the Dependent Care FSA Claim Form, or upload it via the Vita Flex portal (www.vitaflex.net) or via the mobile app. All claims must include a signed claim form along with full and complete documentation of the expense incurred. Required documentation includes written statements/bills from an independent third party which include the dependent's name, the provider name, the dates of care, and the amount charged. Handwritten receipts are acceptable provided they are signed by the provider and they

include all the required information. Copies of balance forward billing statements, cancelled checks, or any receipt without complete documentation outlined above are not considered sufficient documentation.

Provided you have commenced salary reductions, you will be reimbursed for your eligible dependent care expenses as soon as administratively feasible. The specific method by which you will receive your reimbursement is identified in the PDD Fact Sheet. Details of this reimbursement method are outlined in Part 15: Reimbursement Methods. The specific claim reimbursement process is outlined in the welcome letter you receive after you formally elect participation in the Plan. To have your claims processed as soon as possible, please read and follow the directions provided in the Claim Kit, which is mailed to your home after your election or received electronically via e-mail.

Q-11. What is the deadline for submitting claims?

You will have until the Claim Submission Deadline identified in Part 1: PDD Fact Sheet to submit claims for eligible dependent care expenses incurred during the previous Plan Year. All claims must be submitted by the Claim Submission Deadline to be considered for reimbursement. Claims received after the Claim Submission Deadline are not eligible for reimbursement. Additionally, any claims received prior to the Claim Submission Deadline without complete documentation and/or where complete documentation is not submitted by the Claim Submission Deadline are not eligible for reimbursement.

If the Plan is terminated or there is a change in Contractor for Administrative Services prior to the end of the Plan Year for any reason, participants must submit any claims incurred prior to the termination date or date of change in Contractor for Administrative Services, along with complete documentation by the date specified at the time of termination. If Your Employer goes out of business, claim submission deadlines may be significantly shortened and you may not be able to receive any reimbursement, despite having made contributions to your account.

Q-12. What if I terminate my employment during the Plan Year?

If your employment with Your Employer is terminated during the Plan Year, your active participation in the Plan will cease. In some cases, a salary reduction may be made in your final paycheck (which may be after your date of termination) to reflect coverage prior to your termination date. After your last paycheck, no further salary contributions may be made. You may continue to submit eligible expenses that are incurred through the end of the Plan Year if you have a balance in your Dependent Care FSA.

Q-13. When must the eligible Dependent Care FSA expenses be incurred?

Eligible dependent care expenses should be incurred during the Plan Year that you have elected to participate in the Plan. You may not be reimbursed for any expenses incurred before the Plan becomes effective, before your election becomes effective, before you sign the election form, or after the close of the Plan Year. You may, however, be reimbursed for expenses incurred after your termination date, provided they are employment related and incurred prior to the Claim Incurred Deadline. Dependent care expenses incurred while out on a leave of absence are not eligible for reimbursement.

Q-14. Who is eligible to incur Dependent Care expenses?

Any child or individual who is your dependent within the purview of Internal Revenue Code §152 is eligible to incur expenses. If the dependent is a child, the child must be under the age of 13 years old. If the dependent is 13 years of age or older, they must be physically or mentally incapable of caring for himself or herself to qualify as an eligible dependent.

Q-15. What is an "Employment Related" expense?

IRS guidelines require that dependent care expenses must be employment related in order to qualify as eligible expenses. This means your dependent incurs the expenses to enable you, as the employee (and the employee's spouse, if married), to be gainfully employed. The IRS guidelines regarding what qualifies as employment related are very strict and require that you and your spouse (if applicable) actually be at work or looking for work at the time the dependent care is provided.

Q-16. What is an "Eligible Dependent Care Expense"?

You may be reimbursed for employment related dependent care expenses incurred on behalf of any individual in your family who is under age 13, and whom you could claim as a dependent on your federal income tax return; a spouse or any other tax qualified dependent who is mentally or physically incapable of caring for himself or herself. Generally, these expenses must meet all of the following conditions for them to be eligible dependent care expenses:

1. The expenses are incurred for care rendered after the date of your election to receive Dependent Care FSA reimbursement and during the Plan Year to which it applies.
2. Each individual for whom you incur the expenses is:
    - A dependent under age 13 whom you are entitled to a personal tax exemption as a dependent, or
    - A spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself.
3. The expenses are incurred for the care of a dependent (as described above), or for related incidental household services, and are incurred to enable you and your spouse (if applicable) to be gainfully employed.
4. If the expenses are incurred for care provided outside your household and such expenses are incurred for the care of a dependent, mentally or physically incapable of caring for him or herself, who is age 13 or older, he or she must regularly spend at least 8 hours per day in your home.
5. If the expenses are incurred for care provided by a dependent day care center, the center must comply with all applicable state and local laws and regulations including licensing laws and regulations. (For example, in California if a facility provides care for more than six individuals not residing at the facility, then California law requires that the facility be licensed. In this case, the facility must be licensed in order to be an eligible expense under this Plan.)
6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred, or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
7. The expenses must be primarily custodial in nature (as opposed to primarily educational in nature).

If you have questions on eligible expenses, please contact Vita for assistance in seeking clarification prior to making an election to participate. If you plan to have an expense reimbursed and you later find out that it is not eligible, you may not change your election. The best resource for claim eligibility is the searchable database on the Vita Flex website at help.vitacompanies.com or by calling the Vita Concierge. For additional information regarding eligibility of certain expenses, please contact the Vita Concierge at 650-966-1492 or at 800-424-3052 or via e-mail at help@vitamail.com.

You are also encouraged to consult IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an eligible expense if you have any questions. You may also consult IRS Publication 503, which outlines criteria for eligible dependent care expenses. However, please note that there are certain expenses considered eligible by the IRS (either by reference in Publication 503, "Child and Dependent Care Expenses", or by other IRS guidance) that Your Employer and Vita have purposefully excluded from this Plan due to the ambiguity surrounding the expense eligibility. You may order a current copy of IRS Publication 503 by calling the IRS at 800-829-3676 or by visiting www.irs.gov.

These guidelines generally mean that the following types of expenses would be considered eligible, provided the expenses are for the care of a Qualifying Individual:

- Expenses paid to a dependent care center or dependent care provider.
- Expenses paid to an in-home dependent care provider.
- Expenses paid for education of a pre-school child which are incidental to and cannot be separated from the cost of dependent care.
- Expenses paid for summer camps that are custodial in nature and not considered an overnight camp.

Vita retains full authority to make final determinations as to whether or not a claim is considered eligible for reimbursement under the guidelines of the Plan. Vita will take into account whether the expense is deemed eligible according to the IRS, whether the expense is eligible according to the Plan guidelines, and whether appropriate documentation has been provided. Please note that there are certain expenses considered eligible by the IRS (either by reference in Publication 503, Publication 17, or by other IRS guidance) that may not be eligible under this Plan due to difficulty associated with documenting and administering reimbursement for such items.

In any circumstance where there is disagreement between the IRS guidelines (the IRS Code, IRS regulations, or phone advice provided by an IRS customer service representative), the Plan Document and administrative policies of Vita will prevail as the governing practice.

Q-17. What dependent care expenses are not eligible?

Dependent care expenses must be primarily custodial in nature, as opposed to primarily educational. If a dependent care expense is primarily educational in nature, it is not an eligible expense. Expenses for classes and educational enrichment programs are not eligible for reimbursement. Examples of expenses that are not eligible include, but are not limited to: language classes, tutoring, after-school academic enhancement programs, gymnastics or other lessons, music lessons, sports classes or leagues, and overnight camps. Marketing materials and discussions with staff of after-school programs may also be considered to verify the custodial nature versus the educational nature of the program.

Certain expenses related to dependent care are not considered eligible for reimbursement. These include, but are not limited to diapering fees, transportation fees, and late payment fees.

Additionally, any expenses incurred while on a leave of absence are ineligible for reimbursement.

If you have a question about whether a dependent care expense is eligible, please call for clarification prior to making an election to participate. If you plan to have a dependent care expense reimbursed and you later find out that it is not eligible, you may not change your election. For additional information regarding eligibility of certain expenses, contact the Vita Concierge at help@vitamail.com or (650) 966-1492 or (800) 424-3052. Vita retains full authority to make final determinations as to claim eligibility. Vita will take into account whether the expense is deemed eligible according to the IRS, whether the expense is eligible according to the Plan guidelines, and whether appropriate documentation has been provided.

Q-18. What documentation is required for a claim?

The IRS requires specific documentation to substantiate all eligible dependent care expenses. Expenses that do not have complete documentation cannot be reimbursed. For dependent care expenses, a receipt is always necessary. The receipt must identify the following:

- Dependent's name
- Provider's name
- Dates that care was provided
- Amount charged for the care

Receipts for home day care may be handwritten but must include all of the above documentation and must include the signature of the provider.

Insufficient Documentation: The IRS has indicated that copies of cancelled checks alone are not considered sufficient documentation. Balance forward billing statements that do not outline the dates of care and all other required information identified above are also insufficient, as well as documentation outlining the date that a dependent care payment was paid instead of outlining the specific dates of care.

Vita has the authority to request and require any and all documentation it deems necessary to substantiate the eligibility of claims prior to reimbursement. Vita retains full authority to confirm whether a claim is deemed eligible according to the IRS and whether appropriate documentation has been provided.

Q-19. What is the Child and Dependent Care Credit?

Federal tax law permits you to use your Dependent Care expenses as a credit against your federal income tax. However, this tax credit is not available to the extent the Dependent Care expenses are reimbursed to you under a Dependent Care FSA. The general terms of the tax credit are as follows.

- If your adjusted gross income is less than $15,000, the tax credit is 35% of the qualifying Dependent Care expenses that you pay during the year.
- Based on the current tax law, the tax credit will decrease from 35% to 20% of the qualifying expenses as your adjusted gross income increases from less than $15,000 to $43,000 for the year. The maximum credit of 35% is reduced by 1% for each $2,000 of your adjusted gross incomes between $15,000 and $43,000. The following chart outlines the percentage tax credit available based on varying levels of household adjusted gross income:

Less than $15,000	35%	$31,000	27%
$17,000	34%	$33,000	26%
$19,000	33%	$35,000	25%
$21,000	32%	$37,000	24%
$23,000	31%	$39,000	23%
$25,000	30%	$41,000	22%
$27,000	29%	$43,000	21%
$29,000	28%	$43,000 +	20%

- If your adjusted gross income is more than $43,000, the tax credit is 20% of the qualifying Dependent Care expenses that you pay during the year.
- To determine the tax credit, you may take into account only $3,000 of dependent care expenses for one Dependent, or $6,000 for two or more Dependents.

Illustration: Assume you have one Dependent who has incurred eligible Dependent Care Expenses of $3,600, and that your adjusted gross income is $23,000. Since only one Dependent is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage credit available at $23,000 is 30%. Thus, your tax credit would be $3,000 x 30% = $900. If you had incurred the same expenses for two or more Dependents, your credit would have been $3,600 x 30% = $1,080, because the entire expense would have been taken into account, not just the first $3,000.

In some cases, it is more beneficial to take the tax credit rather than participating in the Dependent Care FSA Plan. Because the amount of the dependent care tax credit depends on your adjusted gross income for the year, you must review your individual federal tax situation and determine if it is more beneficial for you to use the reimbursement under the Plan or elect to not be reimbursed and use the federal tax credit. To help you in this decision, you may obtain a copy of IRS Publication 503 "Child and Dependent Care Expenses".

Q-20. Can I participate and claim the Dependent Care Credit on my tax return?

Generally, no, you cannot claim it on your tax return. You may not claim any other tax benefit for the tax-free amounts received by you under this Plan. You must subtract any tax-free reimbursements from the Dependent Care FSA Plan from the maximum dependent care expenses that might otherwise be available or the calculation of the tax credit (the $3,000 or $6,000). Therefore, if you elect the maximum $5,000 dependent care benefit, and you have one dependent, you will not be eligible for a dependent care tax credit, even if you have additional dependent care expenses that exceed the $5,000 tax-free benefit. However, if you have two or more dependents, you may be eligible for a tax credit on expenses between the

$5,000 maximum benefit under the Dependent Care FSA Plan and the $6,000 maximum under the tax credit. Please consult a tax advisor for further information.

Q-21. When would I be better off to include the reimbursements in my income and claim the tax credit?

Generally, if your income marginal federal tax bracket is 15% or less, you will probably come out ahead by not participating in the Dependent Care FSA Plan, and by claiming the credits for dependent care and earned income instead. The higher your income, the more likely it is that you will benefit from the Dependent Care FSA. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of dependents, etc., you will have to determine your own tax position individually in order to make the decision between taxable and tax-free benefits. Consult your tax advisor to confirm the details of your personal situation and the most advantageous election under this Plan.

Q-22. What if the Dependent Care expenses I incur are less than the amount I have elected?

Any unused amount in your Account will be forfeited. Any un-reimbursed balance in your Account will be forfeited and restored to Your Employer if a claim for eligible Dependent Care Expenses has not been submitted by the Claims Submission deadline (outlined in Part 1: PDD Fact Sheet). Forfeited amounts are used to offset administrative expenses, Plan losses, and overall Plan costs. Pursuant to regulatory guidance, employers have the option of retaining any forfeited amounts as long as they are earmarked as relating to the Dependent Care FSA component of the Plan.

Q-23. Will I be taxed on the Dependent Care FSA benefits I receive?

You will not normally be taxed on your reimbursement benefits, up to the maximum limits outlined in this Plan Detail Document. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-24. How do the Discrimination Tests apply to Dependent Care?

The most commonly failed discrimination test is the 55% Average Benefits Test under the Dependent Care FSA component. If your Dependent Care FSA election amount needs to be changed due to a test failure and you have a spouse whose employer offers a Dependent Care FSA Plan, your spouse may be allowed to make a new corresponding election (based on Your Employer's Plan Document). Please refer to the plan document of your spouse's employer to confirm details. If Your Employer has made a Simple Cafeteria Plan election, the discrimination testing requirements will not apply to your plan.

Q-25. How does the Plan coordinate with the Family and Medical Leave Act?

In general, under the Family and Medical Leave Act of 1993 (FMLA), employers with 50 or more employees are required to offer eligible employees up to 12 weeks of unpaid leave during any 12-month period to care for themselves or family members during a serious health condition or for the birth or adoption of a child. FMLA requires employers to continue the group health coverage of an employee on approved FMLA leave and to restore benefits on return from that leave. For purposes of the FMLA, the Dependent Care FSA component of this Plan qualifies as "group coverage" and the FMLA therefore applies to this Flexible Benefits Plan.

If you take leave under the FMLA, you have two potential options regarding your election under the plan:

- You may revoke your existing election under the Plan for the remaining portion of the Plan Year
- You may elect to continue your participation throughout your FMLA Leave.

Your election of one of these two options must be made within 30 days of the start of your FMLA leave and you may not make or apply an election retroactively. If you do not make an election to the contrary as

outlined under Section 7: Election Change Rules, your participation will be deemed to continue during your FMLA leave, and premiums will be due as outlined below. However, it is important to be aware that even if your Dependent Care FSA remains active during your FMLA leave, any dependent care expenses that are incurred during your leave will not be eligible for reimbursement from the Plan. This is because IRS regulations require that you and your spouse (if applicable) must actually be at work or looking for work at the time the dependent care is provided.

If you revoke your election under the Plan while on FMLA leave, claims incurred after the start date of your FMLA leave will not be eligible and thus cannot be reimbursed. If you elect to revoke your election before you go out on leave, you will have the option to reinstate your participation once you return to work. You will have two choices for reinstatement. You can either elect to reinstate your election at the level in effect before the FMLA leave and repay the missed salary reductions, or you can resume coverage at a level that is reduced and resume contributions at the level in effect before the FMLA leave without repaying missed contributions. Examples are provided below. Please note that in either situation, claims incurred during the revocation period are not eligible and, in both cases, the coverage level is reduced by prior reimbursements. You will have 30 days to reinstate your coverage from the date that you return to work.

- Reinstate coverage at the level in effect before FMLA- Linda has a $3,600 Dependent Care FSA election and goes out on FMLA leave for three months, revoking her election with the start of her leave. During the three months that she is on FMLA leave, she misses a total of $900 in salary reductions. When she returns to work, she elects to reinstate her full $3,600 election amount and repays the $900 that was missed while on FMLA leave. She can then use the full $3,600 annual election for claims incurred before or after her leave of absence.
- Reinstate at a reduced level - Mary has a $4,800 Dependent Care FSA election with a per paycheck reduction of $200 and goes out on FMLA for three months, revoking her election with the start of her leave. She misses $1,200 worth of salary reductions while on FMLA leave. When she returns to work, she decides to reinstate coverage at a prorated/reduced amount of $3,600 and she resumes the prior salary reduction level of $200 per paycheck. Mary does not have to pay back the $1,200 in salary reductions that she missed while on FMLA leave, but she will only be able to claim up to $3,600 in reimbursement for claims incurred before or after her leave of absence.

Participants on FMLA leave have the same rights to change benefit elections, such as a change in family status, as do other Participants. If a change occurs while you are on leave, you will have 30 days to make the change effective.

Q-26. What are my repayment options for missed salary reductions during FMLA?

If you choose to continue receiving Plan benefits while on FMLA, you are responsible for paying the same salary reduction amounts you were paying while not on leave. Several payment options are available to you while on FMLA leave:

- Pre-pay basis - You may pre-pay your salary reductions before beginning unpaid FMLA leave. Payments under this option may be made on a pre-tax salary reduction basis from any available compensation. These payments will not be included in gross income, provided all Plan requirements are satisfied.
- Pay-as-you-go basis - Under the pay-as-you-go option, you may make contributions to the Plan during paid or unpaid FMLA leave on the same schedule as if you were not on leave, or you may make equivalent monthly contributions. If you are not receiving compensation during your leave, payments made under this option are made on an after-tax basis. If you are receiving compensation during your leave, such as salary continuation, sick leave, or vacation pay, your contributions may continue during your leave as pre-tax salary reductions.
- Catch-up contributions - You may pay by making "catch-up" contributions after returning from your FMLA leave. Catch-up contributions may be made in a lump sum upon return from your FMLA leave or may be made by adjusting your ongoing salary reductions upon return from your FMLA leave to a new level basis to make up for any missed salary reductions during your leave. These contributions are typically made on a pre-tax basis. However, if necessary, after-tax contributions may also be made for catch-up contributions.

If your FMLA leave spans two Plan Years, you may not defer compensation from one Plan Year to a subsequent one. Therefore, you can only pre-pay Plan contributions on a pre-tax basis until the end of the Plan Year. You will be allowed to make up the amount missed while on leave in the next Plan Year but it must be on an after-tax basis.

Reinstatement to the Dependent Care FSA cannot be retroactive. As with other Plan benefits, you may elect to be reinstated in the Dependent Care FSA upon return from FMLA leave, as long as your request is received within 30 days of your return from leave.

If "catch-up" contributions or unpaid "pay-as-you-go" contributions are due upon return from leave and you do not return to work, the catch-up contributions or unpaid pay-as-you-go contributions are due and payable. Your Employer reserves the right to take make-up salary reductions from any and all compensation payable to you, as the employee, including vacation pay, sick leave or any salary continuation payments. If no compensation is available for salary reductions, you must make direct payments to Your Employer to re-pay the contributions due. Your Employer may consider unpaid contributions as any other debt owed to Your Employer.

If you return to work after a leave and elect to pay catch-up contributions or unpaid pay-as-you-go contributions over the remainder of the Plan Year, but later terminate employment before all catch-up contributions or unpaid pay-as-you-go contributions are made, Your Employer reserves the same right to collect these unpaid contributions out of any available compensation or to collect the make-up contributions directly from you as described above.

Q-27. How does the Plan coordinate with an unpaid leave of absence?

If you go on an unpaid leave of absence, the personnel policies of Your Employer will govern whether you may continue to participate in the Pre-Tax Benefits Plan. Typically, if you are eligible to continue participating in other employee benefit plans, you will also be eligible to continue participating in the Pre-Tax Benefits Plan. And typically, if you are not eligible to continue other employee benefit plans, you will not be eligible to continue participating in the Pre-Tax Benefits Plan. If Your Employer's policies allow for continuation of participation while on unpaid leave, the same provisions apply as under an FMLA leave, as outlined above in this section. If Your Employer's policies indicate that you may not continue, your participation in the Plan will be terminated.

Section 11: HSA Benefits

Q-1. What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a tax-advantaged savings account for health care expenses available to taxpayers in who are enrolled in a qualified high-deductible health plan (HDHP). The funds contributed to an

account are not subject to federal income tax at the time of deposit. Unlike a Flexible Spending Account (FSA), HSA funds are set up in an individual, personal account that is owned by you, and not owned by Your Employer. Thus, all monies in your account accumulate year to year if they are not spent. There is no "use it or lose it" rule, and no such thing as needing to "rollover" monies, as they already belong to you. HSA funds may be used to pay for qualified medical expenses at any time without federal tax liability or penalty. Withdrawals for non-medical expenses are subject to penalties unless the withdrawal occurs after age 65. After age 65, if withdrawals are made for non-medical purposes, the withdrawal amount will be subject to income taxes (similar to a 401k).

Q-2. What are HSA benefits?

The HSA component of the Plan permits you to make pre-tax contributions to a Health Savings Account (HSA) that you establish and maintain with the Plan HSA trustee/custodian. For purposes of this Pre-Tax Benefits Plan, HSA Benefits consist solely of the ability to make such pre-tax contributions under the Plan.

If you elect HSA benefits, then you will be able to provide a source of pre-tax contributions by entering into a Salary Reduction Agreement with Your Employer. Because your share of the contributions will be paid with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

Q-3. Who can participate?

To participate in the HSA benefits, you must be an HSA-Eligible Individual as defined by the IRS. This means that you are eligible to contribute to an HSA under the requirements AND that you are covered under a qualifying High Deductible Health Plan (HDHP) offered by Your Employer and are not covered by any disqualifying non-High Deductible Health Plan. An HDHP is a health plan that meets the specific criteria required to qualify as a High Deductible Health Plan under the IRS (§223), as described in materials provided separately to you by Your Employer. If you elect HSA benefits, you are effectively certifying that you meet all the requirements to be eligible to contribute to an HSA. These requirements include such things as not having any disqualifying coverage - and you should be aware that coverage under a spouse's plan, including a spouse's health FSA, could make you ineligible to contribute to an HSA. To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans). In order to elect HSA benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian and you must provide sufficient identifying information about your HSA to facilitate the forwarding of your pre-tax salary reductions through Your Employer's payroll system to your designated HSA trustee/custodian.

If you elect health FSA benefits, you cannot also elect HSA benefits (or otherwise make contributions to an HSA) unless you elect the Limited (Vision/Dental/Preventive Care) health FSA Coverage Option. In addition, because the health FSA benefit may include a grace period, if you have an election for health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) health FSA Coverage Option) that is in effect on the last day of a Plan Year, you cannot elect HSA benefits (or otherwise make contributions to an HSA) for any of the first three calendar months following the close of that Plan Year, unless the balance in your health FSA Account is $0 as of the last day of that Plan Year. For this purpose, your health FSA Account balance is determined on a cash basis–that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

In the event that an expense is eligible for reimbursement under both the health FSA and the HSA, you may seek reimbursement from either the health FSA or the HSA, but not both.

Q-4. Is my HSA an employer-sponsored plan?

No. An HSA is not an employer-sponsored employee benefit plan. It is an individually owned account that you open with an HSA trustee/custodian to be used primarily for reimbursement of eligible medical expenses as set forth by the IRS. Consequently, an HSA trustee/custodian, not Your Employer, will establish and maintain your HSA. The HSA trustee/custodian to which your salary reductions will be forwarded is chosen by Your Employer. Your Employer limits this to one provider for administrative ease. This selection is not an endorsement of any particular HSA custodian over another, it is merely the selected vendor for Your Employer. Should you wish to establish an HSA, Your Employer's role is limited to allowing you to contribute to that account on a pre-tax salary reduction basis. Your Employer has no authority or control over the funds deposited in your HSA, in the investment funds offered, nor in the performance of any investment account options.

Vita will maintain records to keep track of HSA contributions that you make via pre-tax salary reductions, but Vita will not track whether contributions exceed the federal maximum or exceed the amount that you personally are able to contribute, based on your family members and insurance coverage.

While Vita maintains records of your HSA contributions, Vita does not create a separate fund or otherwise segregate assets for this purpose.

Q-5. What is the maximum contribution to an HSA?

Your annual contribution to an HSA under this Plan is equal to the annual benefit amount that you elect. The amount you contribute must not exceed the statutory maximum amount for HSA contributions for the level of coverage you have elected under your High Deductible Health Plan (single or family) for the calendar year in which the contribution is made. The maximum amounts are set by the federal government, and they change each year, based on a defined Cost of Living Adjustment factor. For current maximums, please refer to the PDD Fact Sheet. An additional catch-up contribution may be made if you are age 55 or older (you must certify your age to Your Employer). This amount is also outlined in the Fact Sheet.

In addition, the maximum annual contribution shall be:

- Reduced by any contribution or matching contribution made by Your Employer
- Pro-rated for the number of months in which you are an HSA-Eligible Individual

Note that if you are an HSA-Eligible Individual for only part of the year, but you meet all the requirements under Code §223 to be eligible to contribute to an HSA on December 1st, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage level (i.e., single or family). However, any contributions in excess of your annual contribution under the Plan for HSA benefits (as described above), but not in excess of the applicable full statutory maximum amount, must be made outside the Plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of Code §223 during the following year, the portion of HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a 10% penalty (exceptions apply in the event of death or disability).

Q-6. How are my HSA benefits paid for under the Salary Reduction Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of HSA benefits that you wish to pay for with your salary reductions. From then on, you make contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or deemed appropriate by the Plan Administrator). For example, suppose that you have elected to contribute up to $1,000 per year for HSA benefits and that you have chosen no other benefits under the Salary Reduction Plan. If you pay all your contributions, then our records would reflect that you have contributed a total of $1,000 during the Plan Year. If you are paid bi-weekly, then our records would reflect that you have paid $38.46 ($1,000 divided by 26) each pay period in contributions for the HSA benefits that you have elected. Such contributions will be forwarded to the HSA trustee/custodian (or its designee) within a reasonable time after being withheld. Your Employer has no authority or control over the funds deposited in your HSA.

Q-7. Will I be taxed on the HSA benefits that I receive?

You may save both federal income taxes and FICA (Social Security) taxes by participating in the Salary Reduction Plan. However, very different rules apply with respect to taxability of HSA benefits than for other benefits offered under this Plan. For more information regarding the tax ramifications of participating in an HSA, as well as the terms and conditions of your HSA, see the communications materials provided by your HSA trustee/custodian and see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

Your Employer cannot guarantee that specific tax consequences will flow from your participation in the Salary Reduction Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA benefits. Remember that the Plan Administrator is not providing legal advice. For the most reliable answer, you may wish to consult a tax advisor.

Q-8. Are HSA contributions eligible salary reductions?

If Your Employer specifically supports the administration of HSA contribution salary reductions, they will be eligible salary reductions under an IRC §125 Plan. If you are currently enrolled in an HSA-qualified High Deductible Health Plan, you have the opportunity to make contributions to a Health Savings Account (HSA). In certain circumstances (based on Plan design), Your Employer may allow you to reduce your salary and redirect these pre-tax monies into your personal HSA account. While HSA contributions are eligible salary reductions under the Plan, Your Employer is under no obligation to handle the administration of such salary reductions. Your HSA salary reductions are not subject to the election irrevocability rules for other Premium, health FSA, and Dependent Care FSA elections. Therefore, you can make changes to your HSA contribution election at any time during the Plan Year, but they must be made on a prospective basis. Please refer to IRC § 223 for detailed eligibility rules and regulations.

Q-9. Who is responsible for making sure HSA contributions are tax code eligible?

You are. While Your Employer facilitates contributions into your personal HSA account, Your Employer has no liability or responsibility to confirm the eligibility of the HSA contribution elections that you make. The IRS rules for when HSA contributions are eligible under the tax code are complex, at best. Confirming the tax eligibility of any HSA contribution is your sole responsibility. Your Employer acts as a conduit to depositing the contributions into your account, but in doing so makes no representation as to the tax code eligibility of those contributions.

Q-10. Who can contribute to an HSA under the Salary Reduction Plan?

Only employees who are HSA-Eligible Individuals can participate in the HSA benefits. An HSA-Eligible Individual is an individual who meets the eligibility requirements of Code §223 and who has coverage under a qualifying High Deductible Health Plan (HDHP) offered by Your Employer, and who is not covered by any other disqualifying health coverage. The terms of the High Deductible Health Plan that has been selected by Your Employer will be further described in materials that will be provided separately to you by Your Employer.

Q-11. Can I change my HSA contribution during the year?

Yes. Unlike elections for premium contributions and FSA contributions, you may change your HSA contribution at any time during the Plan Year. Specifically, you may increase, decrease, completely revoke, or start a new HSA contribution at any time during the Plan Year for any reason. Refer to the enrollment materials that were provided to you by Your Employer or by Vita or contact the Vita Concierge for detailed information about how to make changes to your HSA contribution, and when those changes will take effect. Your ability to make pre-tax contributions to an HSA under this Plan ends on the date that you cease to meet the eligibility requirements.

Q-12. Where can I get more information on my HSA and its related tax consequences?

HSAs are complex tax instruments, and it is important to fully understand the rules and your responsibilities when you maintain an account. There are detailed rules which govern HSAs, including the following:

- Eligibility to make contributions to your HSA
- Restrictions on the amount and when contributions can be made
- Requirement to be covered under a qualifying High Deductible Health Plan
- Requirement to not be covered under any disqualifying coverage
- Distributions from your HSA

IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans) provides a more detailed description of the rules and restrictions that are important to understand. You may also want to confer with your tax advisor as to how an HSA fits into your tax planning.

Section 12: HRA Benefits

Q-1. What is an HRA Plan?

HRA stands for Health Reimbursement Arrangement. The purpose of the HRA component of the Plan is to allow Your Employer to reimburse certain medical expenses for plan participants and their eligible

dependents. Reimbursement limits and eligible expenses are outlined in the PDD Fact Sheet. Reimbursements of medical expenses paid by the HRA Plan generally are excludable from taxable income.

Q-2. What are the different types of HRAs?

There are many different types of Health Reimbursement Accounts. Your employer may offer several different types of HRAs or none at all. Please refer to the Plan Detail Document (PDD) Fact Sheet to confirm the HRA coverage you may be eligible for. Following is a basic overview of the different types of HRAs. More detailed information on each type is provided in the questions below.

Type of HRA	Common Acronym	Description
Integrated HRA	HRA	An Integrated HRA is the most common type of HRA. These plans typically reimburse a portion of medical expenses (deductible, coinsurance, copays) that are not paid for by the underlying health plan. An integrated HRA wraps around a traditional group medical plan (PPO, HMO, or EPO). A plan that provides reimbursement for essential health benefits must be integrated with an underlying health insurance plan and cannot stand alone based on Affordable Care Act (ACA) rules.
Non-Integrated Standalone HRA	Non-Integrated HRA	An N*on*-Integrated HRA i*s a standalone HRA (meaning it stands alone from any underlying medical plan).* These plans may only reimburse health insurance expenses that are not considered essential benefits under the ACA. This restriction allows the HRA to not be subject to the ACA integration rules.
Excepted Benefit HRA	EBHRA	An Excepted Benefit HRA typically provides benefits for dental and vision expenses. It can be provided on a standalone basis (meaning it can be offered separate from a group health plan).
Medical Travel	Travel HRA	A Medical Travel HRA provides reimbursement for specified travel expenses that are incurred in the process of procuring a medical treatment. Sometimes benefits are restricted to certain types of medical care and/or care that is restricted in some states.
Family Planning	Family Planning HRA	A Family Planning HRA provides reimbursement for family plan expenses such as infertility, adoption, or surrogacy expenses.
Individual Coverage	ICHRA	An Individual Coverage HRA provides a fixed dollar allocation to reimburse certain employees for the purchase of individual policy coverage.
Qualified Small Employer	QSEHRA	A Qualified Small Employer HRA allows small employers who do not provide group health insurance to their employees to pay for medical expenses through an HRA.
Retiree-Only HRA	Retiree HRA	An HRA which provides reimbursement for healthcare expenses and/or premiums for retirees.
Lifestyle Spending Account	LSA	A Lifestyle Spending Account provides reimbursement on an after tax basis for certain wellness or lifestyle related expenses, as defined by the employer.

Q-3. Who can become a participant in the HRA Plan?

Plan eligibility criteria are outlined in the PDD Fact Sheet. In certain circumstances, eligibility for the HRA may be contingent upon electing coverage under a specific health insurance plan option.

Q-4. How is my HRA Plan funded?

If you qualify for the HRA offered by Your Employer, an account will be set up by Your Employer. The plan is funded 100% by Your Employer and expenses are paid out of Your Employer's general assets. While an accounting of your designated funds is made, there are no deposits to an actual account made on your behalf. Funds are not set up in trust and there is no separate fund from which benefits are paid. No employee contributions are accepted into the HRA plan.

Q-5. What benefits are offered through the HRA Plan?

Once you become a Participant, the HRA Plan will maintain an account in your name to keep a record of the amount available to you for the reimbursement of eligible health expenses. Your HRA is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of Your Employer), and it does not bear interest or accrue earnings of any kind.

Depending on plan provisions, sometimes benefits include dental and vision expenses. In other circumstances, health expenses are restricted to expenses that are otherwise eligible under your health insurance plan, but not reimbursable by the insurance plan because it is designed to have you pay a portion of those expenses. The specific benefits that are eligible under your HRA are outlined in the PDD Fact Sheet that accompanies this Disclosure Document.

Before the start of each Plan Year, Your Employer will determine a maximum annual amount that may be credited during that Plan Year to the HRA Account of a participant in the HRA Plan. Some employers may choose to credit the full annual amount on the first day of the Plan Year, or the first day an employee becomes an eligible participant in the Plan. If Your Employer chooses to apply credit on a monthly basis instead, your HRA Account will be credited with a pro rata portion of the maximum annual amount, so long as you are an Eligible Employee on the first day of that month. For example, if the maximum annual amount is determined by Your Employer to be $2,400 for the Plan Year, your account will be credited with $200 at the beginning of each calendar month during which you are a Participant, but no credit will be given for a month that you fail to qualify as an Eligible Employee on the first day of that month. Your HRA Account will be reduced by any claim amounts that are reimbursed to you, or for your benefit, for eligible health care expenses incurred by you, your spouse, or your dependents. The amount available for reimbursement of health care expenses as of any given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you as of that date.

After the end of the Plan Year, the unused amount (if any) in your HRA Account may remain available in the next Plan Year, if Your Employer opts to roll those funds over, and provided you are still a Participant (subject to any election you may make to suspend or opt out of participation in the Plan).

Q-6. How are my HRA benefits taxed?

In most cases, reimbursements under your HRA plan will be tax-favored (that is, pre-tax). In some cases, benefits may be offered under the plan that will be reimbursed on a taxable basis. To the extent the plan provides reimbursements for "medical care," the Plan is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45 and an employer-provided medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended and the regulations issued thereunder. However, only certain eligible expenses reimbursed under the Plan are eligible for exclusion from gross income under Code Section 105(b). Other expenses, for example, certain family plan benefits and certain medical travel benefits, do not qualify under the definition of medical care and, therefore, are not eligible for pre-tax reimbursement. Refer to the accompanying PDD Fact Sheet for details on taxation status of covered benefit. Your Employer cannot guarantee the tax treatment to any given Participant, since

individual circumstances may produce differing results. If there is any doubt, you should consult your own tax advisor.

Q-7. How does the HRA Plan work?

The HRA Plan will reimburse you for eligible health care expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- You must submit a claim to Vita and provide any additional information requested by Vita
- A request for payment must relate to health care expenses incurred by you, your spouse, or your dependent during the time you were a Participant under this Plan
- A request for payment must be submitted by the Claim Submission Deadline that is specified in the PDD Fact Sheet.

Claims must be submitted on a Claim Form provided by Vita, uploaded via the Vita Flex online portal at www.vitaflex.net, or via the mobile app. The claim must include the following elements:

- The individual(s) on whose behalf the health care expenses were incurred
- The nature and date of the health care expenses incurred
- The amount of the requested reimbursement
- A statement that such health care expenses have not otherwise been reimbursed and are not reimbursable through any other source. There may also be a requirement that health FSA coverage, if any, has been exhausted.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the health care expenses have been incurred and showing the amounts of such health care expenses, along with any additional documentation that Vita may request (including, but not limited to, proof of a prescription).

Q-8. What expenses are eligible for reimbursement from the HRA Plan?

Only defined expenses are covered by the HRA Plan. Please refer to the PDD Fact Sheet for the definition and criteria for eligible expenses. In some cases, HRAs have an open definition of eligible expenses, in which case any health care expenses (expenses related to the diagnosis, care, mitigation, treatment, or prevention of disease) would be eligible. This will be specified in the PDD Fact Sheet.

Medical HRA Plans

Some examples of eligible health care expenses are (a) insulin; (b) prescribed drugs and medicines (whether or not the drug or medicine could be purchased without a prescription); (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses; (e) dermatology; (f) physical therapy; and (g) contact lenses or glasses used to correct a vision impairment. Your Employer or Vita can provide you with more information about which expenses are eligible for reimbursement.

Some HRA plans have a narrow definition of what is an eligible expense. For example, some HRAs are limited to dental and vision expenses while others restrict eligibility to certain out-of-pocket medical expenses that may not be covered under an underlying group health plan.

Medical Travel HRA Plans

A medical travel expense HRA allows for transportation and lodging expenses for travel necessary to obtain treatment for specific medical services as outlined in the PDD Fact Sheet. Expenses must be for travel outside your area as defined by the Radius Exclusion in the PDD Fact Sheet.

Transportation expenses must be primarily for, and essential to, receiving medical care and not include any element of travel for personal reasons. This includes:

- Bus, taxi, train, or airplane fares
- Mileage reimbursement for driving a personally owned car

- Car services, such as taxis, Uber, Lyft, or another similar rideshare service
- Car expenses associated with driving to receive medically necessary treatment. Actual mileage traveled must be documented. The IRS determines a standard medical mileage rate on an annual basis
- Tolls and parking expenses when incurred specifically to receive the medical care
- Combination of transportation expenses. If transportation to treatment requires multiple modes of transportation, all such expenses would be eligible. For example, the costs for taking an Uber to the airport, the airplane ticket cost, the cost for taking a taxi to the hotel, etc. would all be considered eligible travel expenses, assuming they were necessary in the course of receiving the medical treatment.
- Transportation expenses of a parent who must accompany a child (under the age of 18) who needs medical care
- Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone
- Transportation expenses for a friend, family member, or other non-medically trained support person are not eligible

The cost of lodging while away from home receiving medical care is eligible if all the following requirements are met:

- The lodging is primarily for, and essential to, medical care
- The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital
- The lodging isn't lavish or extravagant under the circumstances
- There is no significant element of personal pleasure, recreation, or vacation in the travel away from home

Examples of eligible lodging include a hotel or Airbnb-type lodging service.

The maximum amount for lodging is $50 per person per night. For example, if a parent is traveling with a child, up to $100 per night would be considered an eligible medical expense for lodging.

Eligible lodging expenses allow for one day on either side of medically necessary treatment plus necessary recovery time as specified by provider.

Note that lodging expenses for an eligible caregiver traveling with the person receiving the medical care are eligible; however, the same restrictive rules apply for defining an eligible travel partner as outlined above for transportation expenses.

Q-9. Are there any limitations on benefits available from the HRA Plan?

Any expense that is outside of the specific definition of eligible expenses for the HRA are not eligible. In addition, for some HRA plans, there are still many items that are not considered medical care expenses and thus are not eligible, even from an open HRA plan. Some examples of expenses that may not be eligible for reimbursement include the following:

Medical HRA Plans

- Pregnancy testing kits
- Over-the-counter drugs or medicines that are purchased without a prescription
- Health insurance premiums for any other plan (including the plan that qualifies you for HRA participation). (Notwithstanding the foregoing, the HRA Account may reimburse COBRA premiums that a participant pays on an after-tax basis.)
- Long-term care services
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a

personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease

- The salary expenses of a nurse to care for a healthy newborn at home
- Funeral and burial expenses
- Household and domestic help (even if recommended by a qualified physician due to an employee's, spouse's, or dependent's inability to perform physical housework)
- Massage therapy for non-medical purposes (without a specific medical diagnosis and treatment plan specified by a medical provider)
- Home or automobile improvements
- Custodial care
- Costs for sending a child with behavioral issues to a special school for benefits that the child may receive from the course of study and disciplinary methods
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement)
- Bottled water
- Maternity clothes
- Diaper service or diapers
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing
- Automobile insurance premiums
- Travel expenses of any sort, including transportation expenses to receive medical care
- Psychotherapy (including psychoanalysis) for non-medical purposes (without a specific medical diagnosis and treatment plan specified by a medical provider)
- Home or automobile improvements
- Marijuana and other controlled substances (including associated paraphernalia) that are in violation of federal laws, even if prescribed by a physician
- Any item that does not constitute "medical care" as defined under Code §213
- Any expense incurred before you became a Participant.

Medical Travel HRA Plans

The following expenses are not eligible for reimbursement under a medical travel HRA:

- Meals (other than meals provided through inpatient care)
- Childcare expenses/babysitting
- Extending an otherwise-medical trip for vacation or for any element of personal enjoyment
- Expenses for a caregiver or travel companion (except for a parent accompanying a child under age 18 or a qualified caregiver who can administer medication, such as a nurse)
- Transportation expenses in the following circumstances:
  - ✓ Going to and from work, even if your condition requires an unusual means of transportation
  - ✓ Travel for purely personal reasons to another city for an operation or for other medical care
  - ✓ Travel that is merely for the general improvement of one's health
  - ✓ The costs of operating a specially equipped car for other than medical reasons

- Any expenses for which no charge is generally made or for which commercial receipts are not available. For example, no reimbursement is available if staying at the home of a relative or friend when no cost would typically be incurred.

Q-10. How do I become a Participant?

If you meet the Eligibility Provisions described in Section 2, and the Underlying Coverage Requirements described in Section 4, you will become a Participant in the HRA Plan on the first day of the calendar month following your submission of a properly completed enrollment form, or the first day of the later month indicated on your enrollment form, in accordance with procedures established by Your Employer, but only if you are an eligible employee on that day.

Q-11. What if I cease to be an Eligible Employee?

If you cease to be an Eligible Employee, your participation in the HRA Plan will terminate at the end of the month in which the terminating event occurs, unless you are eligible for and elect COBRA continuation coverage as described below. In either case, you will be reimbursed for any Medical Care Expenses prior to the date your participation terminates, up to your account balance in the HRA Account, provided that you comply with the reimbursement request procedures required under the HRA Plan (see Q-5 for more information on the reimbursement request process). Any unused portions will not be available after termination of employment. However, if you are rehired within 30 days after your termination, your HRA Account balance will be reinstated.

Q-12. Do unused benefits carry over?

Whether unused benefits carry over to the next plan year is a matter of plan design. Please refer to the PDD Fact Sheet for details on whether any benefits carryover. In certain circumstances, benefits may be structured as a lifetime maximum. In this case there is no carryover, per se. Rather, there is simply a single benefit amount that you are eligible for over the course of your lifetime career under the plan.

Q-13. How does COBRA continuation coverage work with the HRA Plan?

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under Your Employer's major medical or other health insurance plan at group rates. If you, your spouse, or your dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the HRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the HRA Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours
- Your divorce or legal separation from your spouse
- Your becoming eligible to receive Medicare benefits
- Your dependent child ceasing to qualify as a dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing Vita of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. (In the event that family coverage is continued under COBRA, the employee, spouse, and dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

Upon a COBRA Qualifying Event of termination of employment or reduction in hours, you will receive a COBRA election notice that includes detailed information about your COBRA rights and responsibilities. If you have a COBRA Qualifying Event of a divorce or a child no longer being eligible under the plan, you must notify your employer of the Qualifying Event within 60 days.

If your HRA plan is integrated with your medical plan, generally, you must elect both the HRA and the medical plan together. When this is the case, your COBRA elections for the HRA and medical plan will be tied, and you will not be able to elect one without the other.

COBRA is only available for HRA plans that offer healthcare benefits. If your employer offers a plan with benefits that provides reimbursement for expenses that are healthcare related (such as adoption services or lifestyle expenses), COBRA continuation coverage is not available for those plans/benefits.

Q-14. Will I have any administrative costs under the HRA Plan?

Generally, no. Your Employer is currently bearing the entire cost of administering the HRA Plan while you are an Employee.

Q-15. How long will the HRA Plan remain in effect?

Although Your Employer expects to maintain the HRA Plan indefinitely, it has the right to terminate the HRA Plan at any time. The Employer also reserves the right to amend the HRA Plan at any time and in any manner that it deems reasonable, in its sole discretion. An amendment or termination of the Plan could result in the reduction or elimination of HRA Account balances under this Plan.

Q-16. What documentation is required for a claim?

The IRS specifically requires third-party substantiation to document all eligible expenses. Expenses that do not have complete documentation cannot be reimbursed. Do not include any expenses that cannot be appropriately documented in your estimated reimbursement calculation for the year, as they cannot be reimbursed.

Medical HRA Plans

For medical expense claims, the documentation requirements are the same as outlined under Q-21 under the health FSA section (above).

Medical Travel HRA Plans

For medical travel HRA expense claims, additional documentation is required, including:

- Location Information: Home city and city where services are provided
- Treatment Information: Diagnosis and medical procedure
- Billing Information: Billed amount, provider write-off amount (for PPO providers or courtesy discount), insurance payment amount, and net amount paid (these elements are typically provided by an insurance carrier Explanation of Benefits)
- Transportation Expenses: Type of transportation (bus, train, airplane). departure city (must match home city), Destination city (must match location where services are provided), date of transportation (must align with dates of service), transportation dates allow for one day on either side of medically necessary treatment plus necessary recovery time as specified by provider, copy of receipt for all transportation expenses showing the above elements, name of caregiver if applicable (must meet required caregiver/companion guidelines)
- Lodging Expenses: Type of lodging, lodging address (must match treatment location), date of lodging (must align with dates of service), and a copy of receipt for lodging expenses showing the above elements.

Copies of cancelled checks (even with a note in the memo field), credit card receipts, or any receipt without complete documentation of the items outlined above alone are not considered sufficient documentation.

Vita has the authority to request and require any and all documentation it deems necessary to substantiate the eligibility of claims prior to reimbursement. Vita retains full authority to confirm whether a claim is deemed eligible according to the IRS and the Plan and whether appropriate documentation has been provided. Final authority to accept or deny a claim based on sufficiency of the documentation provided rests with Vita.

Q-17. What does integration mean?

Integration refers to whether you can be covered under the HRA plan on a standalone basis or whether you must also be covered under a group health plan. Integration is required for certain HRAs in order to comply with the requirements of the Patient Protection and Affordable Care Act, as amended (the ACA) and the applicable regulations. When plan integration is required, the plan will require one of the following two coverage options:

- You are covered under your employer's group health plan, or
- You are covered under either your employer's group health plan or another group health plan.

Refer to the PDD Fact Sheet that accompanies this Disclosure document under the section titled, "Plan Integration/Underlying Health Plan Coverage Requirement" for details.

If your HRA plan is not integrated, that means the HRA plan can stand alone without reference to any other coverage that you may or may not have.

For additional, more technical information: To the extent the Plan provides an HRA that is integrated with another group health plan (as described in 26 C.F.R. 54.9815-2711(d)(1)), the Plan is intended to be an HRA as defined under IRS Notice 2002-45, the Eligible Expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants' gross income under Code §105(b), and the Plan is intended to be an employer-provided medical reimbursement plan under Code §§105 and 106 and regulations issued thereunder, and to satisfy the minimum value method of integration described in IRS Notice 2013-54 and DOL Tech. Rel. 2013-3, as detailed in Treas. Reg. §54.9815-2711(d) and DOL Reg. §2590.715-2711(d), through integration with a high-deductible health plan. The Plan is not intended to be integrated with Medicare Parts B and D.

Q-18. How does an HRA interact with an HSA?

If you are covered under an HDHP, in order to preserve the ability to make contributions to an HSA, reimbursements under a pre-tax medical HRA or medical travel HRA must be made after the statutory deductible has been satisfied.

The Vita Flex medical travel HRA platform does not retain information on the specific type of medical plan coverage for each eligible employee. Therefore, at the time of claim, you must self-attest whether you are covered under an HDHP plan and making contributions to an HSA. When you so attest, you will be required to present a copy of an Explanation of Benefits showing the date you have satisfied the federal statutory deductible. Expenses incurred after that date will be reimbursed from your HRA. You will bear the sole responsibility for tax liability pursuant to accurate representation of whether you are subject to the statutory deductible to preserve your ability to make HSA contributions.

Q-19. How does an HRA interact with a health FSA?

If you also participate in a health FSA, your medical expenses will be reimbursed from your HRA first. Any remaining amount that is not reimbursed by your HRA is eligible for reimbursement under your health FSA plan.

Q-20. What is an ICHRA and how does it work?

An ICHRA is an Individual Coverage HRA. It is a type of HRA plan that can be integrated with, and reimburse premiums for, individual health insurance coverage if certain conditions are met. Please refer to the PDD Fact Sheet accompanying this Disclosure Document to confirm if your plan is an ICHRA and the provisions of the plan. ICHRA offer reimbursement of premiums for individual medical insurance purchased in the individual market. In some circumstances, other medical expenses (such as copays and/or deductibles) may also be reimbursed. Your individual coverage premiums must be substantiated to receive reimbursement. In order to be covered under an ICHRA, your employer may not offer you traditional group health insurance and you

must secure individual coverage outside of the Exchange. meaning you cannot also receive a federal subsidy (premium tax credit) for your individual coverage.

Q: 21. What is an QSEHRA and how does it work?

A QSEHRA is a Qualified Small Employer HRA. It is a type of HRA plan that can be offered only be employers who employ fewer than 50 full-time equivalent employees in the prior calendar year. A QSEHRA can reimburse employees for medical care that is incurred during the QSEHRA period of coverage. Reimbursement of individual major medical health insurance premiums as well as other medical expenses such as copays and deductibles can be covered. Please refer to the PDD Fact Sheet accompanying this Disclosure Document to confirm if your plan is a QSEHRA, the specific expenses that are eligible, and the annual limit under your plan.

If a QSEHRA is offered, the plan will automatically terminate on the last day of the calendar year during which your employer no longer qualifies to offer the plan based on employer size. In the event the Plan terminates for this reason, you may submit reimbursement requests for expenses incurred prior to plan termination and submitted no later than the claim submission date provided.

Q-22. What happens if my claim for benefits is denied?

If a claim for benefits is denied, you have a right to appeal the denial. An outline of the information necessary, the requirements, and the timeline for appealing a denied claim can be found under Section 17: Claims and Appeals Procedures. The claim procedures for health reimbursement claims fall under the "Post Service Claim" review rules as established by Department of Labor regulations.

Q-23. When might forfeitures happen?

Any Integrated HRA benefit that remains unused at the end of any plan year that is not carried over in accordance with Section 3.05(c) (if applicable and as specified in the PDD Fact Sheet) shall be forfeited and shall remain the property of the Employer/Plan Sponsor. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the timeframe provided in this PDD. Forfeited amounts are used to offset administrative expenses, Plan losses, and overall Plan costs.

To the extent a participant terminates employment while unspent benefit amounts still remain, if COBRA continuation coverage is not elected, any yet unclaimed potential benefits (notwithstanding any claims incurred prior to the termination date) will be forfeited after the date the individual fails to qualify as an eligible participant.

Q-24. Who is the Plan Administrator?

Your Employer is the Plan Administrator and the named fiduciary for the HRA Plan. Vita is the Contractor for Administrative Services that maintains accounting records and processes reimbursements on behalf of Your Employer.

Q-25. May I elect to suspend or opt out of my HRA Account?

Yes. If you participate in the HRA Plan, you will be ineligible to make contributions to a Health Savings Account (HSA). (Participation in the health care plan may also make you ineligible for HSA contributions. For more details, consult the summary for that plan or contact the health care plan's administrator.) You can remove the HRA as an obstacle to HSA contributions for a Plan Year if you elect to "suspend" your HRA Account before the beginning of that Plan Year. Whether you elect to suspend your HRA Account is up to you.

You may elect to suspend your HRA Account for any future Plan Year by submitting a Suspension Election Form to Your Employer before the beginning of that Plan Year. Your suspension election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

By electing to suspend your HRA Account for a Plan Year, you agree to permanently forgo reimbursements from your HRA Account for health care expenses incurred during that Plan Year, except for certain qualifying

dental or vision expenses. Health care expenses incurred in the Plan Year before the suspended Plan Year may be reimbursed, so long as there was no suspension in effect for that prior Plan Year. You must apply for reimbursement, by submitting an application in writing to Vita, no later than March 31st following the close of the Plan Year in which the health care expense was incurred.

In lieu of a suspension of your HRA Account, you may elect to permanently opt out of and waive any right to reimbursements from your HRA Account for expenses incurred after the election takes effect, except for limited-scope dental or vision expenses. This opportunity will be offered at least annually by the HRA Plan.

Your Employer will not contribute to your HRA Account after any opt-out election takes effect or for any Plan Year for which you have suspended your participation in the HRA Plan.

Section 13: Commute Benefits

Q-1. What is the purpose of the Commute plan?

The purpose of the Commute component of the Plan is to allow eligible employees to pay for Commute benefits with pre-tax dollars contributed through employee salary reductions and, in some cases, contributions from Your Employer. This plan may help you save money on your transportation expenses by allowing you to pay for those expenses on a pre-tax basis. Under the Plan, you elect Commute benefits and agree to pay your share of the cost of those Commute benefits by entering into a salary reduction

arrangement. A salary reduction arrangement allows you to contribute on a pre-tax basis instead of receiving the same amount of regular pay. This arrangement helps you because neither your salary reduction nor the benefits you elect are subject to federal income or employment taxes, saving you Social Security and income taxes on the amount of your salary reduction.

Q-2. How are Commute benefits provided?

Commute benefits provided by the Plan generally take the form of reimbursements for eligible Commute expenses. For Transit Pass benefits, you may be issued transit passes or a Smartcard that allows you to pay Transit Pass expenses by loading contributions onto the card and thus pay for them directly with your card without having to pay up front and then request reimbursement.

Q-3. What specific benefits are available under the Plan?

The Plan offers the following Commute benefits. Participants may pay on a pre-tax salary reduction basis for their share of the following expenses for commuting to work.

- Transit Pass benefits
- Commuter Highway Vehicle (Vanpool) benefits
- Qualified Parking benefits

Your Employer may also have a policy for the reimbursement of certain bicycle commuting expenses, which are described below.

Your Employer may issue transit passes in some circumstances and may issue Smartcards to pay for Transit Pass benefits. Reimbursements for qualified Parking benefits may be made on a debit card which can then be used to pay for later qualified Parking benefits.

Q-4. What are the tax savings available under the Plan?

You save both federal income tax and FICA (Social Security and Medicare) taxes by participating in the Commute component of the Plan. Following is an example of the tax savings you might experience as a result of participating in the Plan.

Suppose that you pay $100 per month for parking on or near Your Employer's premises. Also assume that you are not senior management, in which case no contributions are made by Your Employer for parking. Your monthly take-home pay (based on the assumptions indicated below) will be $1,834 if you pay your parking costs on an after-tax basis, or $1,856 if you pay on a pre-tax basis instead. (This is because if you participate in the Plan, you will be considered for tax purposes to have received $2,400 gross pay for the month, rather than $2,500, with $100 contributed for Commute benefits.) So, you save $22 per month ($264 annually) by participating in the Plan. Of course, your actual tax savings will vary depending on your circumstances. Additional tax savings might be available under state and local law (e.g., there may be state income tax savings too).

Q-5. What are "Commute Expenses"?

"Commute Expenses" are the expenses you incur or pay that are reimbursable under the Plan if you are a Participant at the time the Commute benefits are provided to you. (Commute benefits are provided on the date you receive a Transit Pass as defined below, or similar item, or in any other case, the date you use the Commute benefits.) Reimbursable Commute expenses are limited to Transit Pass expenses, Commuter Highway Vehicle expenses and qualified Parking expenses, which are defined as follows:

- Transit Pass expenses. Qualifying Transit Pass expenses for mass transit passes, fare cards, vouchers, etc. for expenses incurred for commuting to work. These include expenses incurred or paid for a pass, token, fare card, voucher, or similar item (Transit Pass) for transportation (a) on mass transit facilities (such as train, bus, subway or ferry), whether or not publicly owned; or (b) provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver).

- Commuter Highway Vehicle (Vanpool) expenses. Qualifying Commuter Highway Vehicle expenses for commuting to work, including vanpools operated by public transit authorities or private sources. These include expenses incurred or paid for transportation in a Commuter Highway Vehicle if such transportation is in connection with travel between your residence and place of employment. A Commuter Highway Vehicle is any highway vehicle with a seating capacity of at least six adults (not including the driver) and for which at least 80% of the mileage for a year is (a) for purposes of transporting employees in connection with travel between their residences and their places of employment, and (b) on trips during which the number of employees transported for such purposes is at least half of the adult seating capacity of the vehicle (not including the driver).
- Qualified Parking expenses. These include expenses incurred or paid for parking at or near your regular place of employment with Your Employer, or expenses incurred to park your car at a location from which you commute to your regular place of employment by (a) carpool; (b) a Commuter Highway Vehicle; (c) mass transit facilities; or (d) transportation provided by any person in the business of transporting persons for compensation or hire, if such transportation is in a Commuter Highway Vehicle.

Be sure to ask the Vita Concierge for help if you have any doubts about which expenses are – and are not – reimbursable. You may not submit expenses incurred by anyone other than you.

Your Employer may also sponsor a bicycle commuting expense reimbursement policy. This plan covers costs for the purchase of bicycles, bicycle parts, bicycle repairs, and bicycle storage. The bicycle plan is solely employer-sponsored, meaning pre-tax salary reductions cannot go towards this benefit. The employer-sponsored amount is regulated by the IRS and outlined in the PDD Fact Sheet. If you are enrolled in the bicycle plan, you are prohibited from simultaneously participating in the Transit or Parking Plan.

Q-6. Are daily expenses reimbursable?

Yes. The Plan reimburses transportation expenses including daily expenses. The Plan does reimburse for daily or metered parking.

Q-7. How do I get benefits under the Plan?

To benefit from the Plan, you must make an election through the process designated by Your Employer and agree to salary reductions to pay for your share of the cost of the benefits you elected. The cost of Commute benefits is the monthly benefit amount you elected. (In some situations, a portion of that cost is paid by Your Employer. When this is the case, it will be outlined in the PDD Fact Sheet.) The exact deadline for enrollment is determined by Your Employer. If you delay returning your enrollment documentation, that may delay the start of your Commute benefits. You do not have to make an election and begin contributing as soon as you become eligible to do so. As long as you remain an Eligible Employee, you will be able to elect benefits for any future period of coverage. The period of coverage is typically monthly and will be outlined in your enrollment materials and administered by Vita. You will be reminded of your opportunity to make an election and invited to make a benefit election or change your existing election during an annual benefits Open Enrollment period, although you can make a new election at any time, and you are not locked into any election for any specific period of time.

Q-8. Other than Open Enrollment, when can I change my election?

You may change your election for Commute benefits, opt in as a new participant, or stop your participation at any time throughout the year. When you make a change, the change will become effective on the payroll cycle after the change is processed by Your Employer.

Q-9. What happens if my employment terminates, or I stop being eligible?

If your employment with Your Employer is terminated, you will cease to be a Participant and you will not be able to make any more contributions to the Plan, nor will you continue to receive benefits under the Commute Plan component. You may, however, still be able to get reimbursed for eligible Parking expenses

incurred before your participation ended, but only if you submit claims within 90 days after your termination date. Your debit card will be deactivated upon your termination date.

If you contributed after-tax ("post-tax") funds to a Commute Plan via salary reductions, and you have a balance in your account at the time your employment is terminated, you may request a refund of the remaining after-tax balance. You must submit your refund request in writing directly to Your Employer within 60 days after your employment termination date.

If you are on a temporary leave of absence (but you are otherwise still an Eligible Employee), you will not be able to use the funds in your Commute Plan(s) until you have returned to Active employment status.

If you cease to be an Eligible Employee for any other reason (such as a reduction of hours) but you remain a Participant, you will not be able to make any more contributions to the Plan and you will not be credited with any more employer contributions, but you will continue to be able to use your Commute account balance to receive benefits under the plan until it is exhausted–at which time you will cease to be a Participant.

If you become an Eligible Employee again before your Employee status is lost, your ability to elect benefits and make contributions will be restored for future Periods of Coverage in which you are a Participant and an Eligible Employee.

Q-10. Will I pay any administrative costs under the Plan?

No. The Plan's administrative costs are paid entirely by Your Employer.

Q-11. How long will the Plan remain in effect?

Although Your Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate all or any part of the Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended.

Q-12. What happens if my claim for benefits is denied?

If your claim for benefits is denied in whole or in part, you will be notified in writing by Vita within 90 days of the date Vita received your claim. Upon receipt of an adverse benefit determination, you may appeal the denial (seek reconsideration of the denial). You must submit your appeal in writing to Vita no later than 60 days after the annual claim submission deadline (if you are still employed by Your Employer), OR 120 days after your employment termination date (if you are no longer employed by Your Employer). This appeal step is a prerequisite to pursuing any other avenues of relief.

Q-13. How will participating in the Plan affect my 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 other benefits (e.g., pension, disability, and life insurance) which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

Q-14. How are my salary reduction amounts calculated?

Your salary reduction for a pay period for the Commute benefits that you elect will be an amount equal to (a) the monthly cost of all the Commute benefits you elected, less the monthly equivalent of any Employer contributions toward those benefits, (b) multiplied by the number of Periods of Coverage (i.e., months) remaining in the Plan Year, (c) divided by the number of pay periods remaining in the Plan Year. However, in calculating the number of pay periods in the Plan Year, the third pay period, if any, ending in any month may not be counted. (So, solely for purposes of computing compensation reduction amounts for the Plan, there are typically 24 pay periods in a full Plan Year.) Salary reductions for Commute benefits will usually not be taken from the paycheck for the third bi-weekly pay period ending in any month.

Here's an example of how this works: Suppose that, effective March 1, 2020, you have elected to be reimbursed for up to $180 per month for qualified Parking expenses, you have chosen no other Commute benefits, and you are not part of senior management. Your salary reduction for each bi-weekly pay period

(other than the third pay period ending in any month) will be $90. This was calculated as follows: (a) $180 (your share of the monthly cost) times 10 (the number of months remaining in the Plan Year) = $1,800; (b) divided by 20 (the number of pay periods remaining in the Plan Year, excluding the third pay period ending in any month) = $90 per pay period, assuming no salary reduction would be taken from the third pay period ending in any month.

Q-15. What is my "Commute Account"?

If you elect Commute benefits, an account called a Commute Account will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the pre-tax salary reductions you have paid for such benefits during the Plan Year and any contributions made by Your Employer toward your benefits. Your Commute Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of Your Employer) and it does not bear interest. Separate subaccounts will be maintained for each Commute benefit you elect.

Q-16. What are the maximum Commute benefits that I may elect?

You may elect any amount of Commute expense reimbursement that you wish under the Plan, subject to the maximum reimbursement amounts described below.

The maximum amount that may be contributed to your Commute Account (including Employer contributions, if any, and your salary reductions) cannot exceed the maximum amount specified in IRS Code §132(f). These annual maximum amounts are outlined in the PDD Fact Sheet.

The amounts for future years may be adjusted for inflation. If the adjusted amounts are then known, they will be made available at the time of the Plan's Open Enrollment period and will be outlined in the Fact Sheet.

Q-17. What amounts will be available for reimbursement at any particular time?

The amount available for reimbursement will not at any time exceed your Commute Account balance. (Your Commute Account is the bookkeeping record that is credited with salary reductions and any contributions from your Employer and reduced by reimbursements.)

The amount available for reimbursement of Commute expenses at any particular time will be limited by the applicable balance of your Commute Account at the time your claim is paid. Using the example in Q-14, suppose that you paid $300 of qualified Parking expenses by April 2nd ($150 for March and $150 for April). At that time, the Parking portion of your Commute Account would only have been credited with $180 ($90 times 2 pay periods), so only $180 would be available for reimbursement as of April 2nd (assuming that you had not received any prior reimbursements). You would have to wait to submit the remaining $120 of Commute expenses until after you had received the appropriate credits to your Commute Account.

The monthly reimbursement of funds contributed on a pre-tax basis cannot exceed the maximum amount specified in IRS Code §132(f), regardless of the balance in your Commute Account at the time the Commute expense was incurred or paid. The annual maximum amounts are outlined in the PDD Fact Sheet.

Q-18. When are Commute expenses "incurred" or "paid"?

For Commute expenses to be reimbursed, they must have been *incurred* or *paid* while you are a participant. A Commute expense is *incurred* when the service that gives rise to the expense is provided. A Commute expense is *paid* when you formally pay for the service; it is not paid when you are formally billed for or charged for the service. You may not be reimbursed for any Commute expenses arising before the Plan became effective, before your Salary Reduction Agreement became effective, or for any expenses incurred or paid after a separation from service. You also cannot carry forward unreimbursed expenses to a future Period of Coverage.

Q-19. What must I do to be reimbursed for my Commute expenses?

You will have to take certain steps to be reimbursed for your Commute expenses. When you incur an expense that is eligible for payment, you must submit a claim to Vita using the Vita Flex online portal. You

may also be required to include bills, invoices, statements from an independent third party, parking receipts, used transit passes or other evidence of payment showing the amounts of such payments, together with any additional documentation that Vita may request, showing that the Commute expenses have been incurred or paid and the amount of such Commute expenses. Please note that, by law, Vita may not be able to reimburse you for the expense of a Transit Pass if a "voucher" (or something similar) is readily available.

If you are provided with a Transit Pass that is purchased directly by Your Employer, your Commute Account will be debited directly for the cost of the Transit Pass. You will not need to submit a claim for reimbursement.

You will have until March 31st following the end of the Plan Year (or until April 15th following the end of the Plan Year, if the Employer/Plan Sponsor offers the Grace Period option) to submit a claim for reimbursement of Commute expenses incurred or paid during the Plan Year. However, if following the date on which the Commute expense was incurred or paid you cease to be a Participant in the Plan (e.g., because of termination of employment), you will only have up to 90 days after the date you ceased to be a Participant to submit a claim for reimbursement. You will be notified in writing if any claim for benefits is denied.

Q-20. Can I use a debit card to pay for my Commute expenses?

Yes. The Vita Flex Debit Card issued to you is an MCC-restricted debit card, meaning that the Parking or Transit service provider's "Merchant Category Code" must meet the Plan's substantiation requirements. If you have enrolled in the Parking plan, your debit card may be used at parking lots and garages as well as daily metered parking areas that accept payment by credit or debit card, for the purpose of employment-related parking. If you have enrolled in the Transit plan, all Transit expenses must be paid with the debit card; you may not submit "manual" claims for reimbursement from your Transit plan. You may use the debit card to purchase Transit Passes from a Transit Agency directly, or from a merchant who is authorized to sell Transit Passes (provided such a merchant has an appropriate MCC).

Q-21. What if I overestimate my Commute expenses?

If your reimbursement request was for less than your current Commute Account balance, the unused amounts in your Commute Account will roll over and be available for future expenses, so long as you continue to participate in the Plan. You may need to adjust the election for the next monthly Period of Coverage in order to use up your surplus Commute Account balance. For example, if your monthly Parking election (and anticipated monthly expense) is $100, but you only incur $75 worth of Parking expenses in January, you might want to change your election for February to $75 in order to use up the $25 surplus from January. Then you can increase your election back to $100 for March, prior to the election change deadline specified by Your Employer.

Q-22. What if I underestimate my Commute expenses?

You cannot carry forward unreimbursed expenses from one monthly Period of Coverage to another. If your Commute expenses during a monthly Period of Coverage exceed your Commute Account balance (including your credits for that month and any balance carried forward from prior months), you cannot be reimbursed for the excess expense. For example, if you begin participating in April with a Parking election of $100 and then incur qualified Parking expenses for April in the amount of $150, you may be reimbursed for $100 of the April parking expenses, but you cannot seek reimbursement of the excess $50 in Parking expenses out of any future month's credits.

Also, see Q-18, which addresses what to do if you seek reimbursement for an expense before all salary reduction amounts for that monthly Period of Coverage have been credited.

Q-23. When would I risk forfeiting my Commute benefits?

If you have any amounts credited to your Commute Account at the time you terminate employment or stop being eligible for any other reason, any portion not used for eligible Commute expenses incurred or paid prior to the termination will be forfeited. Also, any Commute Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Commute expense was incurred or paid shall be forfeited. All amounts described as forfeited shall be

forfeited to Your Employer. Forfeited amounts are used to offset administrative expenses, Plan losses, and overall Plan costs.

Any employer contributions for a Plan Year in excess of the amount used to reimburse your Commute expenses incurred or paid during that Plan Year will be forfeited to Your Employer after the last day on which you could have submitted those expenses for reimbursement.

Q-24. Will I be taxed on the Commute benefits I receive?

Generally, you will not be taxed on your Commute benefits – up to the limits set out under the Plan. However, Your Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits you receive depend on the validity of the claims you submit. For example, to qualify for tax-free treatment, your Commute expenses must be qualified Parking expenses, Commuter Highway Vehicle expenses, or Transit Pass expenses as defined by IRS Code §132. If you are reimbursed for a claim that is later determined not to be for Commute expenses, you will be required to repay the amount. Ultimately, it is your responsibility to determine whether each payment to you under this Plan is excludable for tax purposes. You may wish to consult a tax advisor.

Q-25. Is there a cash-out option?

No. There is no cash-out option under the Plan.

Section 14: Simple Cafeteria Plan

Q1. Which employers are eligible for a Simple Cafeteria Plan?

Your Employer must have employed an average of 100 or fewer employees in either of the two preceding years.

Q2. Which employees are eligible to participate in a Simple Cafeteria Plan?

In general, all employees with at least 1,000 hours of service during the preceding Plan Year (other than certain excludable employees) must be eligible to participate in the Plan. Each employee who is eligible to participate must be able to elect any benefit available under the Plan (subject to any terms and conditions that apply to all participants).

Q3. How much is my Employer required to contribute?

Employers who make a Simple Cafeteria Plan election must also elect one of the following two funding options. Employees who are not Key Employees or Highly Compensated Employees must receive employer contributions of at least:

- 2% of the employee's compensation for the Plan Year, or
- The lesser of 6% of the employee's compensation for the Plan Year or twice the employee's salary reductions.

Q4. How does this affect Discrimination Testing?

Meeting the requirements of a Simple Cafeteria Plan provides a safe harbor for all discrimination tests that would otherwise be required, under IRS code Section 105, Section 125, and Section 129. This reflects all of the discrimination tests required under a non-Simple Cafeteria Plan.

Section 15: Lifestyle Spending Accounts

Q-1. What is a Lifestyle Spending Account (LSA)?

The purpose of the Lifestyle Spending Account component of the Plan is to allow for reimbursement of specific, defined life expenses for plan participants and their eligible dependents. Eligible expenses are determined by Your Employer. Reimbursement limits are outlined in the PDD Fact Sheet. Reimbursements are fully taxable to plan participants.

Q-2. Who can become a participant in the Lifestyle Spending Account?

Plan eligibility criteria are outlined in the PDD Fact Sheet.

Q-3. How is my LSA Plan maintained?

If you qualify for the LSA offered by Your Employer, an account will be set up by Your Employer. The plan is funded solely by Your Employer out of Your Employer's general assets. While an accounting of your designated funds is made, there are no deposits to an actual account made on your behalf.

Q-4. What expenses are eligible under the LSA?

There are a variety of different type of expenses that can be reimbursed through an LSA. Your Employer has selected specific categories and expenses that are eligible for reimbursement under this plan. The specific benefits that are eligible under your LSA are outlined in the PDD Fact Sheet that accompanies this Disclosure Document.

Q-5. What is the maximum benefit?

Before the start of each Plan Year, Your Employer will determine a maximum annual amount that may be reimbursed during that Plan Year for an LSA. Some employers choose to credit the full annual amount on the first day of the Plan Year, or the first day an employee becomes an eligible participant in the Plan. Some

employers elect to allocate the benefit on a monthly basis so that you would receive 1/12 of the annual benefit each month so long as you are an Eligible Employee on the first day of that month. Under this option, Your LSA Account will be reduced by any claim reimbursements made to you. The amount available for reimbursement of health care expenses as of any given date will be the total amount credited to your LSA as of such date, reduced by any prior reimbursements made to you as of that date.

Your Employer may elect to prorate the annual benefit for employees who become eligible on a mid-year basis.

The maximum benefit amount, how your benefit is allocated (annual or monthly), and whether benefits are prorated for mid-year new hires are outlined in the PDD Fact Sheet that accompanies this Disclosure Document.

Q-6. What happens to unspent funds?

Unspent funds are typically forfeited at the end of the plan year. In some cases, Your Employer may allow a carryover of some amount of unspent funds. Details on whether Your Employer allows any rollover and the amount/conditions for a rollover is outlined in the PDD Fact Sheet that accompanies this Disclosure Document. Forfeited amounts are used to offset administrative expenses, Plan losses, and overall Plan costs.

Q-5. How are claims submitted?

The LSA Plan will reimburse you for eligible expenses to the extent that you have a positive balance in your LSA Account. The following procedure should be followed:

- You must submit a claim with the required document to Vita
- A request for payment must be submitted by the Claim Submission Deadline that is specified in the PDD Fact Sheet.

Claims must be submitted on a Claim Form provided by Vita, uploaded via the Vita Flex online portal at www.vitaflex.net, or via the mobile app. The claim must include the following information:

- The individual(s) on whose behalf the health care expenses were incurred
- The nature and date of the expenses incurred
- The amount of the requested reimbursement

Each claim must be accompanied by required documentation as outlined in Q-10 below.

Q-6. Are there any limitations on benefits available from the LSA?

Only expenses in the specific expense categories outlined in the accompanying PDD Fact Sheet are eligible for reimbursement. If a lifestyle expense is not specifically included, it is not eligible for reimbursement under the plan.

Q-7. What if I cease to be an Eligible Employee?

If you cease to be an Eligible Employee, your participation in the LSA Plan will terminate on your date of termination. Generally, the LSA plan will not be subject to COBRA. In the circumstance when the LSA reimburses medical expenses that may be eligible expense under Section 105/106 or if it is integrated with another HRA that is subject to COBRA, then the LSA may be eligible for COBRA continuation, as well.

Whether the LSA plan is subject to COBRA is outlined in the PDD Fact Sheet that accompanies this Disclosure Document.

Q-8. How does COBRA continuation coverage work with the LSA Plan?

In many cases LSA plans are not group health plans. If your LSA includes elements of group health coverage, it will be subject to COBRA. In this case, refer to the description of how COBRA works under an HRA for a description of how COBRA works. In some cases, if your LSA is determined to be subject to COBRA, the coverage may be tied to your medical election under COBRA (meaning you must elect both together).

Q-9. Are my LSA benefits taxable?

Yes. The nature of the Lifestyle Spending Account is that the reimbursements will be taxable to you as ordinary income.

Q-10. What documentation is required for a claim?

Documentation for LSA claims must be a receipt or combination of other documents that collectively include the following elements:

- Amount of expense
- Date expense incurred
- Store, vendor or company from whom purchase was made
- Type of expense
- Person for whom expense is incurred

Copies of cancelled checks, credit card receipts, or any receipt without complete documentation outlined above alone are not considered sufficient documentation.

Vita has the authority to request and require any and all documentation it deems necessary to substantiate the eligibility of claims prior to reimbursement. Vita retains full authority to confirm whether a claim is deemed eligible according to the Plan and whether appropriate documentation has been provided. Final authority to accept or deny a claim based on sufficiency of the documentation provided rests with Vita.

Q-11. Who is the Plan Administrator?

Your Employer is the Plan Administrator and the named fiduciary for the LSA Plan. Vita is the Contractor for Administrative Services that maintains accounting records and processes reimbursements on behalf of Your Employer.

Section 16: Reimbursement Methods

Q-1. How is the money in my account reimbursed?

Your Employer has made an election as to how all participants of Your Employer's Plan will be reimbursed; you do not have a personal choice in the matter of reimbursement method. You will receive your reimbursement via Direct Reimbursement (either direct deposit or paper check).

Q-2. How does Direct Reimbursement work?

Under the Direct Reimbursement method, you will receive your reimbursement directly payable to you. In most cases, this will occur via a direct deposit to your bank account. In some cases, this will occur via paper check. Direct deposit reimbursements are processed weekly, typically for deposit into personal bank accounts each Friday. If your employment has been terminated and you are due a reimbursement, you will still receive your reimbursements via this same method. In some cases, Vita will receive your bank account information from Your Employer. Otherwise, your personal bank account information will need to be provided by you directly to Vita.

Please note, if Your Employer allows paper checks to be issued, Your Employer may be charged for every paper check that is processed. Your Employer and Vita would like to encourage you to receive your reimbursements via direct deposit, even when paper checks are an option provided by Your Employer.

Q-3. Are debit cards available under the Plan?

Certain plans have debit cards available for advance payment of eligible expenses via their health FSA, Commute benefits, Health Savings Account, or HRA election. Your Employer will indicate whether debit cards are available under your Plan (refer to the PDD Fact Sheet). There are many complex reasons (both administrative and financial) why Your Employer may or may not choose to offer debit cards as an additional reimbursement method. If Your Employer offers debit cards, then Q-4 through Q-9 of this section apply; otherwise, they do not apply.

Q-4. How do debit card transactions work?

In addition to the standard reimbursement methods outlined above, Your Employer's Plan may also provide merchant-restricted debit cards. All debit card transactions are considered "advanced" reimbursements, and, in many cases, are still subject to the standard claim documentation requirements, even though they are "advanced" reimbursements. Your debit card is linked directly to your Health and/or Commute related elections but does not apply to any Dependent Care FSA reimbursements.

You may use your Vita Flex Debit Card to pay for eligible expenses without having to pay out of pocket up front and then wait to be reimbursed. You may use your Vita Flex Debit Card to pay for eligible expenses at any provider with a qualified Merchant Category Code (MCC). The merchant code is the transaction code used by the provider when they swipe debit card expenses, which classifies their type of business. Qualified merchants for Health expenses include doctor's offices, dentist offices, drugstores, pharmacies, and hospitals. Qualified merchants for Commute expenses include public transit agencies, authorized dealers of transit passes, public parking lots and garages. Certain limited expenses will be exempt from the normal documentation requirements. Thus, in certain limited situations, you may be able to swipe your Vita Flex Debit Card for eligible expenses and you will not have to submit additional documentation.

Using a Vita Flex Debit Card does not mean that documentation requirements are eliminated entirely. It is important to save all your receipts in the event they are requested to verify the eligibility of the expense. For some expenses, you will still be required to submit receipts and documentation to substantiate that your claim is an eligible expense. This documentation rule was established by the IRS as a requirement for all debit card users under a tax-advantaged Health or Commute benefits plan. The IRS outlines certain special exceptions when documentation is not required for debit card transactions, but for all other debit card transactions documentation is required.

Please note that debit cards become inactive on your date of termination. If you decide to extend your coverage under Federal COBRA, your debit card will not be reactivated. You will be required to submit eligible expenses using one of the manual claim submission methods outlined above.

The Vita Flex Debit Card has a three year lifespan and must be kept from year to year. You will not be reissued a new debit card within the three year period following the initial issuance of the debit card, which means that even if you do not participate in consecutive years, you will still be required to use the same Vita

Flex Debit Card originally issued within the three year period. If your debit card is lost or stolen, you will be charged the replacement fee and it will be deducted from your available Health or Commute Account balance.

Q-5. What are the documentation requirements for debit card transactions?

The IRS requires that all Flexible Spending Account claims have third party documentation in order to substantiate the eligibility of the claim. There are two different types of transactions for your debit card.

- Type #1: Pending Substantiation – Additional documentation required
- Type #2: Auto-Approved – No additional documentation required

Type #2 debit card expenses are considered "auto-approved." No additional documentation is required because they follow the specific guidelines outlined by the IRS for expenses that do not require follow-up documentation. You are NOT expected to know or to guess which type of swipe you have incurred. If your expense is a Type #1 debit card charge and thus requires documentation, you will be sent electronic or paper correspondence from Vita (within 14 days of the date of purchase) requesting the necessary documentation. The correspondence will reference the specific date on which you incurred the expense by swiping your card. You must submit the necessary documentation by the date listed on the correspondence in order to prevent the debit card from becoming suspended or having to repay the amount of the unsubstantiated debit card charge. If your expense is a Type #2 debit card expense, Vita will also send you an electronic or paper correspondence confirming that the expense is auto approved and that there is no further action required on your part.

Q-6. What happens if I don't submit the needed documentation?

If you do not submit the required documentation by the date listed on your debit card transaction correspondence, your debit card will ultimately be suspended, and the amount of the debit card transaction will need to be repaid to the Plan. To repay ineligible debit card transactions, Your Employer will offer a combination of the following options:

- Electronic Funds Transfer (EFT)
- Paper Check
- Future Claim Reduction
- Payroll Deduction
- Imputed W-2 Income

To determine which repayment methods are available through Your Employer, please contact the Vita Concierge (refer to Section 18: Plan Questions). If you terminate employment prior to successfully repaying an amount associated with an ineligible or unsubstantiated debit card expense, then your Vita Flex account will be frozen, and you will not receive any additional eligible claim reimbursements until such time that your outstanding repayments are collected. If repayment is not collected prior to the end of the Plan Year, then Your Employer reserves the right to impute the amount of the uncollected repayment as taxable income on your W-2 for the calendar year.

Q-7. What happens if I charge an ineligible expense to my debit card?

When you activate your debit card, you are accepting responsibility to only use it to purchase items that are eligible under the Plan. Each time you swipe your debit card, you are confirming this responsibility. If, after you send the documentation, it is deemed that the expense is not eligible, you will be required to repay the ineligible expense to the Plan. Please refer to the repayment options outlined under "Q-6. What happens if I don't submit the needed documentation?" for additional information. Please note that use of your Vita Flex Debit Card to purchase known ineligible expenses is considered fraud against the Plan. Persistent purchasing of ineligible items may result in your card being permanently deactivated and other potential action against you.

Q-8. When is a debit card transaction recorded on my account?

Your debit card transactions are NOT necessarily always recorded on the date you actually swipe your card and make your purchase. All debit card transactions have a "settlement date" which is the date the merchant actually completes the transaction. Visa and MasterCard debit card merchants have up to two (2) business days after the card swipe occurs to "settle" a debit card transaction. While many merchants settle card swipe transactions the same business day, some settlement dates may be delayed. The automatic claims processing system in Vita Flex keys your transaction off of the settlement date, not the actual transaction date.

This could be important if you swipe your card near your employment termination date or near the end of the Plan Year. For example, if you swipe your card on December 30th, but the Visa or MasterCard merchant actually settled the transaction on January 2nd, the purchase will have a transaction date of December 30th in the current Plan Year, but a settlement date of January 2nd in the following Plan Year. In this case, the automatic claims processing system will deny the expense as incurred outside the Plan Year.

If you have made an election in the following Plan Year (or plan to elect COBRA continuation coverage in the event of this situation occurring near your employment termination date), this issue may not be a problem for you. However, if this automatic claim process causes a problem such that you might forfeit a portion of your election, you may make a request that the transaction date for claims incurring purposes be changed from the settlement date to the actual purchase date. Vita will honor such requests if they are received by Vita up to sixty (60) days after the settlement date. This is the same sixty (60) day period that you would normally be given to submit documentation for debit card expenses (when such documentation is necessary). Requests to override the settlement date will be denied if they are received more than sixty (60) days after the settlement date. All requests to change the transaction date to the actual purchase date so that the claim may be considered "incurred" on the actual purchase date must be received by Vita within sixty (60) days of the settlement date or they cannot be processed.

Q-9. Where can I use my debit card to pay for over-the-counter (OTC) items?

You will not be able to use your debit card at non-health care merchants such as supermarkets and grocery stores or health care related merchants that are deemed by the IRS to sell less than 90% of health care related items unless they have a special inventory system in place. Your card will be declined at stores that have not implemented this system and you will have to provide another form of payment. This special inventory system codes each item in the store as eligible or ineligible under a health FSA. Ineligible items are not allowed to be purchased using a Vita Flex Debit Card. For example, you will be allowed to purchase a package of Band-Aids using your debit card but not a bottle of multivitamins. If you try to purchase an ineligible item, your card will be declined.

Section 17: Claims and Appeals Procedures

The following section outlines your rights and responsibilities for filing health benefit claims under the health plan elements of this plan. If your claim for reimbursement is denied, you have the right to be notified of the

denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for benefits under the health plan components of this plan are outlined below.

Q-1. How do I submit a claim for benefits?

When you are entitled to benefits, you may submit claims for such benefits by completing and filing a claim with the Contractor for Administrative Services (Vita). Any such claim must be in writing and must include all information and evidence that Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. Vita may request any additional information necessary to evaluate the claim.

Q-2. When will I be notified of a decision on my claim?

You are entitled to notification of the decision on your claim within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond Vita's control. Vita is required to notify you prior to the expiration of the initial 30-day period of the need for the extension and the day by which you can expect to receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then Vita will notify you regarding what additional information you are required to submit, and you will be given at least 45 days from receipt of the notice to submit the additional information. If you do not submit the additional information, Vita will make the decision based on the information in hand.

Q-3. What information will be provided in a claim denial notice?

If a claim is wholly or partially denied, your will receive a notice that includes the following information:

1. Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available
2. Any denial code (and its corresponding meaning) that was used in denying the claim
3. The specific reason or reasons for the denial
4. A reference to the specific plan provision(s) on which the denial is based
5. A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary
6. An explanation of the steps that you must take if you wish to appeal the denial and the time limits applicable to such steps, following a denial on review
7. A description of the plan's internal and external review procedures and the time limits applicable to such procedures, following a denial on review
8. (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; or
9. (B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Q-4. How do I appeal a claim denial?

You have the right to an internal appeal and, if applicable, an external review by an independent review organization. Your request for an internal appeal must be in writing, must be submitted to Vita, and must

include all the following information plus any additional documentation that you have not already provided to Vita.

- Your name and address (as the formal claimant)
- The fact that you are disputing a denial of a claim or Vita's act or omission
- The date of the notice that Vita informed you of the denied claim
- The reason(s), in clear and concise terms, for disputing the denial of the claim or Vita's act or omission.

If you wish to appeal the denial of a claim, you must file an appeal with the Plan Administrator on or before the 180th day after you receive the Plan Administrator's notice that the claim has been wholly or partially denied. If you do not file an internal appeal within this 180-day period, you lose your right to appeal. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You must be provided, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to your claim. An appeal may also include any comments, statements, or documents that you may desire to provide. An appeal should also include any relevant documentation not already provided to the Plan Administrator.

You shall lose the right to appeal if the appeal is not timely made. If an appeal is timely made, you have the right to an internal appeal and, if applicable, an external review by an independent review organization.

Q-5. What are the Elements of an Internal Review?

Any time before the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to Vita. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. You will be provided, upon request and free of charge, all such documents and other information relevant to your claim.

When reviewing your internal appeal, Vita will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If Vita receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for Vita's notice of final internal adverse benefit determination. Similarly, if Vita identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you, and you will be given a reasonable opportunity to respond to that new rationale before the due date for Vita's notice of final internal adverse benefit determination. Vita shall consider the merits of your presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as Vita may deem relevant.

The internal appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Plan who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

If the internal appeal determination will be based on the medical judgment of a health care professional retained by Vita, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional retained for purposes of the internal appeal will not be an individual who was consulted in connection with the determination that is being appealed or any subordinate of that individual.

Q-5. What is the timing of the process?

Vita will notify you of the Plan's benefit determination on review within 60 days after receipt by the Plan of your request for review of an adverse benefit determination.

Q-5. What happens if my appeal is denied?

If your internal appeal is wholly or partially denied, the notice that you receive from Vita will include the following information:

1. Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available
2. The specific reason for the denial upon review
3. A reference to the specific Plan provision(s) on which the denial is based
4. Any denial code (and its corresponding meaning) that was used in denying the claim
5. A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits
6. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request
7. A statement of your right to bring an external appeal

You have a right to seek an external third-party review of Vita's denial of the appeal unless the benefit denial was based on a failure to meet the Plan's eligibility requirements. An external appeal must be filed with the external reviewer within 4 months of the date you were served with Vita's response to the appeal request. If you do not file the appeal within this 4-month period, you lose your right to appeal. For example, if you received the internal appeal decision on January 3, you must appeal the decision by May 3 (or, if that is not a business day, the next business day thereafter).

The external reviewer must notify you and Vita of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other state or federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

Q-6. Can I file a lawsuit if my claim remains denied?

You will not be allowed to take legal action against the Plan, Your Employer, the Contractor for Administrative Services, or any other entity to whom administrative or claims processing functions have been delegated, unless you exhaust all internal remedies/appeal rights. However, you are not required to pursue external review in order to preserve his right to file a lawsuit. (In fact, as explained later in this summary, you may be unable to take further legal action if you pursue an external appeal because the external appeal process results in a binding determination.)

The exhaustion requirement applies to all types of claims under the Plan, including: (1) recovery of benefits under the Plan, (2) enforcement of your rights under the terms of the Plan, and (3) clarification as to your rights to future benefits under the terms of the Plan. Unless otherwise provided under the Plan or required pursuant to applicable law, legal action for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Section 18: Privacy Rights

Q-1. Does the Plan comply with the HIPAA Privacy Rule?

This Plan complies with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As required, a copy of the Privacy Notice is provided as an addendum to this Plan Document/PDD Disclosure document. Both a short summary of the Privacy Notice and full Privacy Notice can be found as an addendum at the end of this document.

If you have questions about the privacy of your health information under the Plan, please contact the Plan Administrator or the Privacy Official named in Your Employer's Privacy Policy.

Q-2. How does Vita protect the privacy of my protected health information?

As a Business Associate of the Plan Sponsor, Vita is contracted to handle specific administration elements for the pre-tax plan. As such, Vita collects personal, financial, banking, and health-related information that is necessary for the processing of claims, for fulfilling legal and regulatory requirements, and for assisting clients with policy or administration questions. In addition, Vita maintains pertinent personal identifying data (such as Social Security Numbers). Vita also maintains records on any health conditions disclosed or provided in claims for reimbursement specifically in order to comply with IRS guidelines.

Vita may collect non-public personal information as well as protected health information about you from many sources, including information we receive about you on applications or other forms and information about your transactions with us. Vita places strict limits on who receives specific information about customer accounts and other personally identifiable financial data and protected health information. Vita never rents or sells your personal information to anyone.

The Privacy Notice for Vita can be referenced at www.vitacompanies.com/privacy-policy.

Q-3. Who is allowed to access my account information?

You as the Participant are the only person allowed to receive account information through any mode of communication (i.e., via e-mail or over the phone from the Vita Concierge). You may grant access to additional persons who may make transactions on your account on your behalf, including account information and claim inquiries. Any such authorization must be received in writing (either via U.S. Mail using Vita's "Account Authorization Form" or via e-mail at help@vitamail.com). Vita will keep this information on file, and you must notify Vita if you would like to change or terminate the status of any individual to whom you have granted account access at any time in the future.

Q-4. Does the Privacy Rule guarantee anonymity?

While all plans are subject to the HIPAA Privacy Rule, it is not the case that complete anonymity can be expected under the plans. Reimbursements cannot be truly anonymous from the employer. Privileged employer users will have access to Employer level reimbursement reports and participant-specific data is required for both plan accounting and discrimination testing purposes. While employer representatives are not privy to the specifics of reimbursement details, the fact that claims and reimbursements were made, the amount of the reimbursements, and the plan from which reimbursements were made is information that is available to privileged users. This may be of particular importance to some participants of medical travel HRA plans.

Section 19: General and Legal Provisions

Q-1. How is the plan funded?

The component elements of this plan may be paid for either by participant salary reductions or out of Plan Sponsor general assets. Refer to the PDD Fact Sheet for details on funding for specific plan components. For any amounts paid for by the Plan Sponsor, there is no trust, other fund, or segregated monies from which benefits are paid. Plan benefits are paid for entirely by the Plan Sponsor general assets.

Q-2. What laws are this plan subject to?

It is intended that this Plan will meet all applicable requirements of the Internal Revenue Code, and all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

Q-2. What is Administrator Discretion?

The Plan Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits, and to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides, in its sole discretion, that a Claimant is entitled to them. The Plan Administrator's failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Plan Administrator may delegate some of its administrative duties to agents. Any construction, interpretation, or application of the Plan by the Plan Administrator is final, conclusive, and binding. The Claim Administrator has no authority to exercise discretion.

Q-3. Can this Plan be amended or terminated?

While it is the intention of the Employer/Plan Sponsor that this Plan will continue indefinitely, the Employer/Plan Sponsor reserves the right to amend, terminate, or merge the Plan at any time for any reason.

Q-4. Can benefits be lost or assigned?

Yes. You may lose all or part of your account balance if the Plan Administrator or Claim Administrator cannot locate you when your benefit becomes payable to you. You are responsible for keeping the Plan Administrator and the Claim Administrator informed of any changes in your address and phone number. You should also keep a copy, for your records, of any notices you send. You may not alienate, sell, transfer, anticipate, commute, pledge, attach, encumber, or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that your estate may receive your

benefits upon your death. Any attempt to assign your benefits will not be recognized, except as required by law.

Q-5. What are the severability rules of the plan?

If any part of the Plan is subsequently invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

Q-6. Does this plan coordinate with other plans?

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy. To the extent that reimbursement is made under an insurance policy, no claim for benefits or reimbursement can be made for the same expenses. Likewise, claims for benefits under one component plan may not be duplicate submitted under a second component plan. For example, if an expense is reimbursed under an FSA or HRA, it is not eligible for reimbursement under an HSA.

Q-7. What are the tax implications of the plan?

While the pre-tax elements of this plan are intended to provide pre-tax benefits as outlined under Section 5, the Employer/Plan Sponsor do not make any guarantee that the amounts paid to the Participant hereunder will be excludable from the Participant's gross income for federal, state, or local tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes.

Q-8. What is the effect on my employment rights?

The Plan is not to be construed as giving you any rights against the Plan except those expressly described in this document. The Plan is not a contract of employment between you and the Plan Sponsor. It shall also not be construed as a right of any individual to continue in the employ of the Employer/Plan Sponsor or as a limitation of the right of the Employer/Plan Sponsor to discharge any of its employees, with or without cause.

Section 20: Plan Questions

Q-1. What if I have general questions about the Plan or Vita Administration?

Vita Administration Company is retained by Your Employer to perform a substantial portion of Plan administration responsibilities. The "brand name" of the platform for Vita Administration Company's administrative service for pre-tax benefits is Vita Flex. If you have general Plan questions or questions about the administration of the plan through Vita Flex, please feel free to contact the Vita Concierge.

Mailing Address	Phone/E-mail Inquiries	Claim Submissions:
Vita Flex 1451 Grant Road, #200 Mountain View, CA 94040	Phone: (650) 966-1492 (800) 424-3052 E-mail: help@vitamail.com	Fax: (650) 964-FLEX (3539) (866) 964-FLEX (3539) Mail: Use Mailing Address E-mail: claims@vitamail.com

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vita

Pre-Tax Benefits Plan

Addendum – HIPAA Privacy Notice

THS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Short Summary of Privacy Notice

A. Overview. This Summary of Privacy Practices summarizes how medical information about you may be used and disclosed by your Employer/Plan Sponsor's pre-tax benefits plan (the "Plan") or others in the administration of your claims, and certain rights that you have. For a complete, detailed description of all privacy practices, as well as your legal rights, please refer to the Full Privacy Notice (also known as the Notice of Privacy Practices) below.

B. Our Pledge Regarding Health Information. The Plan is committed to protecting your Protected Health Information (PHI). With respect to your PHI and your electronic protected health information (ePHI), the Plan is required by law to:

- Maintain the privacy of any health information that identifies you
- Provide you with certain rights related to your health information
- Provide you with a copy of this Notice detailing our legal duties and privacy practices
- Follow all privacy practices and procedures currently in effect (as detailed in this Privacy Notice)
- Notify you in the event of a breach of Protected Health Information

C. Use and Disclose Protected Health Information. The Plan may use and disclose your protected health information without your permission to facilitate your medical treatment, for payment of any medical treatments, and for any other health care operation. The Plan will disclose your health information to employees of your Employer as necessary for plan administration functions; but those employees may not share your information for employment-related purposes. Your protected health information may also be used or disclosed without your permission as allowed or required by law. Otherwise, the Plan must obtain your written authorization for any other use and disclosure of your health information. Neither the Plan nor your Employer/Plan Sponsor can retaliate against you if you refuse to sign an authorization or revoke an authorization you had previously given.

D. Reproductive Healthcare. There are additional protections provided for PHI relating to reproductive healthcare (rPHI). Reproductive PHI may not be disclosed for the purpose of conducting a criminal, civil, or administrative investigation for any person for the mere act of seeking, obtaining, providing, or facilitating reproductive healthcare. When a request for rPHI is made, the disclosing entity must obtain a signed attestation affirming that the use or disclosure is not for a prohibited purpose.

E. Your Rights Regarding Your Protected Health Information. You have the right to inspect and copy your health information, to request corrections of your health information, and to obtain an accounting of certain disclosures of your health information. You also have the right to request that additional restrictions or limitations be placed on the use or disclosure of your medical information, or that communications about your medical information be made in different ways or at different locations.

F. How to File Complaints. If you believe your privacy rights have been violated, you have the right to file a complaint with us or with the Office for Civil Rights. The Plan will not retaliate against you for making a complaint.

Full Privacy Notice

A. Introduction. Your Employer sponsors an employee benefits Plan that includes various benefits that constitute pre-tax benefits plans under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including, but not limited to medical, dental, vision, and health care flexible spending account benefits. The Plan has been established and maintained to provide benefits to our employees, their dependents, and other participants. The Plan provides this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive.

B. The Plan vs. Your Employer. The information in this notice addresses the uses and disclosures the Plan may make of your protected health information. It's important to note that these rules apply to the Plan, not to your employer - that's the way the HIPAA rules work. If you participate in an insured plan or an HMO option, you will also receive a privacy notice directly from the Insurer or HMO. The Plan must comply with the general HIPAA provisions of this notice, although the plan sponsor reserves the right to change the terms from time to time and to make any revised notice effective for all PHI that the Plan maintains. You can always request a copy of the most current privacy notice from the Privacy Officer.

C. This Notice. The Plan is required by law to maintain the privacy of your Protected Health Information (PHI). This notice describes the legal obligations of the Plan relative to your information and your legal rights regarding your PHI held by the Plan under HIPAA. Among other things, this Privacy Notice describes how your PHI may be used or disclosed to carry out treatment, for claim payment, for health care operations, or for other purposes that are permitted or required by law. It describes your rights with respect to your PHI and how you can exercise those rights. The Plan is also required to provide this Notice of Privacy Practices (the "Privacy Notice") to you.

D. Protected Health Information (PHI). The HIPAA Privacy Rule protects only certain health information known as protected health information. This means any identifiable health information obtained from the Plan by you or others that relates to your physical or mental health, the health care you have received, or payment for your health care. The definition includes demographic information and health information that relates to a past, present, or future physical or mental condition that is collected from you or created or received by a health care provider, by the plan, or by your Employer on behalf of a pre-tax benefits plan. It is health information that relates to the provision of health care to you, or to the past, present or future payment for the provision of health care. Further, it is health information that could be used to identify an individual or for which there is a reasonable basis to believe that it could be used to identify an individual. PHI includes information of persons living or deceased. PHI includes almost all individually identifiable health information held by this Plan, whether received in writing, in an electronic medium, or as verbal communication.

E. Reproductive Healthcare. There are additional protections provided for PHI relating to reproductive healthcare (rPHI). Reproductive healthcare includes the healthcare of any individual in all matters related to the reproductive system and to its functions and processes. The Privacy Rule prohibits any entity from disclosing any rPHI for the purpose of conducting a criminal, civil, or administrative investigation into or impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive healthcare, where such healthcare is lawful under the circumstances in which it is provided. The prohibition also restricts disclosing rPHI to identify any person for the purpose of conducting such investigation or imposing such liability. Lastly, when a request for PHI is made which may potentially include rPHI, the disclosing entity must obtain a signed attestation affirming that the use or disclosure is not for a prohibited purpose.

F. General Rules for Use and Disclosure of PHI. The HIPAA Privacy Rule generally allows the use and disclosure of your health information without your permission (known as authorization) for purposes of health care treatment, payment activities, and health care operations (as outlined below in more detail). For each category of use and disclosure, several examples are provided, however, not every use or disclosure in a category will be listed. It is also possible that some of the examples presented below may not be applicable because they don't typically apply to employer sponsored welfare benefit plans. Regardless, the following is an overview of how your PHI may be used and/or disclosed without authorization.

1. For Treatment: Your PHI may be used or disclosed to facilitate medical treatment or services by providers. This includes providing, coordinating, or managing health care by one or more health

care providers (doctors, nurses, technicians, medical students, pharmacists, or other hospital personnel who are involved in taking care of you). Treatment can also include coordination or management of care between a provider and third party as well as consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

2. For Payment: Your PHI may be used or disclosed to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. This includes activities by the Plan, other plans, or providers to obtain premiums, make coverage determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits, with a utilization review or pre-certification service provider, with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments, or, at your request, to verify that claims were paid correctly or to advocate for a correction in how claims were paid.

3. For Health Care Operations: Your PHI may be used or disclosed for other Plan operations. These uses and disclosures are necessary to run the Plan. This includes activities by this Plan for plan administration purposes (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use medical information in connection with conducting quality assessment and improvement activities, underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss coverage, conducting or arranging for medical review, legal services, audit services, and fraud/abuse detection programs; business planning and development such as cost management and plan renewal management so that informed decisions can be made regarding any such prospective changes to benefit plans; and business management and general Plan administrative activities, including evaluating an employee's eligibility and administering the employee benefit plans or to providing you with information about benefits available to you under your current benefits plans. The Plan is prohibited from using or disclosing PHI that is genetic information about an individual for underwriting purposes.

The amount of health information used, disclosed, or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purpose. The HIPAA Privacy Rule also prohibits the use of "genetic information" for "underwriting purposes," with the exception of the underwriting of long-term care policies.

G. Disclosure for Plan Purposes. There are several additional types of use and disclosure that are allowed under the Privacy Rule:

1. To Employer/Plan Sponsor: The Plan and any contract administrator, health insurance issuer, or business associate servicing the Plan will disclose Protected Health Information to the Employer/Plan Sponsor only to permit the Employer/Plan Sponsor to carry out plan administrative functions for the Plan consistent with the requirements of the HIPAA Privacy Rule ((45 CFR §164.501). Any disclosure to and use by the Employer/Plan Sponsor of Protected Health Information will be subject to and consistent with this Privacy Notice. The Plan may use or disclose your health information to provide coverage under the Plan, or for modifying, amending, or terminating the Plan.

2. To Business Associates, Subcontractors, Brokers, or Agents: The Plan may contract with individuals or entities known as Business Associates to perform various functions on behalf of the Plan Sponsor or to provide certain types of services to the Plan. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your PHI, but only after they agree, in writing with us, to implement appropriate safeguards regarding your PHI.

For example, the Plan may disclose your PHI to a Business Associate to administer claims or to provide support services such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us. Our Business Associates are required to have each of their subcontractors or agents agree in writing to provisions that impose at least the same obligations to protect PHI as are imposed on Business Associates by the Business Associate Agreement required by HIPAA regulations.

3. To Plan Sponsor Employees: For the purpose of administering the Plan, your PHI may be disclosed to certain employees of the Plan Sponsor. However, those employees will only use or disclose that information as necessary to perform plan administrative functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

4. Summary Health Information: Summary Health Information is plan information that summarizes participants' claims or demographic information, from which names and other identifying information have been removed. Summary Plan Information may be used or shared by the plan as it does not contain protected health information.

H. Other Allowable Uses or Disclosures of Your Health Information. In addition to the use and disclosure categories above, the following categories describe other possible ways that your PHI may be shared and/or disclosed outside of the Plan and/outside of your Employer. In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made - for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The Plan is allowed to use or disclose your health information without your written authorization for the following activities:

For each category of use or disclosure, an explanation is provided of what is meant and some examples are presented. Not every use or disclosure in a category will be specifically listed. However, all of the ways your PHI may be used and disclosed will fall within one of the categories.

1. Workers' Compensation: Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws.

2. As Required by Law: The Plan may disclose your PHI when required to do so by federal, state, or local law for law enforcement or specific government functions. This assumes such disclosure complies with and is limited to the relevant requirements of such law. For example, the Plan may disclose your PHI when required to do so by national security laws or public health disclosure laws, or to a governmental agency or regulator with health care oversight responsibilities.

3. Disclosures Required by Law: Disclosures of your health information as required by law

4. To Avert a Serious Threat to Health or Safety: The Plan may use and disclose your PHI when it is perceived to be necessary and under a good-faith belief that releasing your protected health information will prevent or lessen a serious and imminent threat to public or personal health or safety. This assumes such disclosure is made to someone reasonably able to prevent or lessen the threat (or to target of the threat) and includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.

5. Public Health Activities: Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects. These actions generally include, but are not limited to, the following:
    - To prevent or control disease, injury or disability
    - To report births and deaths

- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify state or local health authorities, as required, regarding particular communicable diseases.

6. Victims of Abuse, Neglect or Domestic Violence: Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk).
7. Lawsuits, Judicial, and Administrative Proceedings: Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process by someone else involved in the dispute (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).
8. Law Enforcement Purposes: Disclosures to law enforcement officials required by law or legal process. These actions generally include, but are not limited to, the following disclosures:
    - In response to a court order, subpoena, warrant, summons, or similar process
    - To identify or locate a suspect, fugitive, material witness, or missing person
    - About the victim of a crime, if you agree or, under certain limited circumstances, the Plan is unable to obtain the victim's agreement, but disclosure is necessary for immediate law enforcement activity
    - About a death that may have been the result of criminal conduct
    - About criminal conduct
    - To provide evidence of criminal conduct on the Plan's premises
    - In emergency circumstances to report a crime, the location of the crime or victim, or the identity, description or location of the person who committed the crime.
9. Coroner, Medical Examiners and Funeral Directors: Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
10. Organ, Eye, or Tissue Donation: Disclosures to organ procurement organizations, organ banks, or other entities to facilitate organ, eye, or tissue donation and transplantations after death.
11. Research Purposes: Disclosures of PHI to researchers when (1) individual identifiers have been removed, or when an institutional review board or privacy board has reviewed the research proposal, and (2) established protocols to ensure the privacy of the requested information and approved the research. Certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project must be met.
12. Health Oversight Activities: Disclosures to health oversight agencies for activities authorized by law. These oversight activities include, for example: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with regulatory programs or civil rights laws.
13. Specialized Government Functions: Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
14. HHS Investigations: Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule.
15. Inmates: Disclosures to correctional facilities, or custodial law enforcement officials about inmates of a correctional institution or persons who are under the custody of a law enforcement official. In this case, your PHI may be disclosed to the correctional institution or law enforcement official, if

necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

16. National Security and Intelligence Activities: Disclosures to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

17. Military and Veterans: Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command to appropriate military commands.

Except as described in this HIPAA section, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

I. Required Disclosures. The following is a description of disclosures of your PHI the Plan is required to make.

1. Government Audits: The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy and Security rules.

2. Disclosures to You: Upon request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan is also required, when requested, to provide you with an accounting of most disclosures of your PHI where the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

3. Notification of a Breach: The plan is required to notify you in the event that the Plan (or one of our Business Associates) discovers a breach of your unsecured PHI, as defined by HIPAA.

J. Other Disclosure Rules. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization.

1. Authorizations: Other uses or disclosures of your PHI not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of PHI for fundraising or marketing purposes, will not be made without your written authorization. If you provide us with an authorization to use or disclose PHI about you, you may revoke that authorization at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, the Plan will no longer use or disclose PHI about you for the reasons covered by your written authorization. However, such revocation will only be effective for future uses and disclosures; it will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You should understand that all revocations are prospective, and the Plan is unable to take back any disclosures the Plan has already made under your authorization and that the Plan is required to retain our records of care provided to you.

2. Personal Representatives: The Plan will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc. so long as you provide us with written authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA Privacy and Security rules, the Plan does not have to disclose information to a personal representative if the Plan has a reasonable belief that:
    - You have been, or may be, subjected to domestic violence, abuse or neglect by such person;
    - Treating such person as your personal representative could endanger you; or
    - In the exercise of our professional judgment, it is not in your best interest to treat the person as your personal representative.

3. Spouses and other Family Members: With only limited exceptions, the Plan will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if the Plan has

agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications. Such information includes, but is not limited to, Plan statements, benefit denials, and benefit debit cards and accompanying information.

4. Authorizations for Psychiatric Notes, Genetic Information, Marketing, and Sale: In general, and subject to specific conditions, the Plan will not use or disclose psychiatric notes without your authorization; the Plan will not use or disclose PHI that is genetic information for underwriting purposes; the Plan will not sell your PHI, i.e. receive direct or indirect payment in exchange for your PHI, without your authorization; the Plan will not use your PHI for marketing purposes without your authorization; and the Plan will not use or disclose your PHI for fundraising purposes unless the Plan discloses that activity in this Notice.

K. Employer/Plan Sponsor's Obligations. Employer/Plan Sponsor is in compliance with the following practices regarding using/not using or disclosing/not disclosing your PHI.

1. Not use or further disclose the information other than as permitted or required by this Section, the Plan, or such other plan documents or as Required by Law, which shall have the same meaning as the term "required by law" under the HIPAA Privacy Rule.
2. Restrict sharing of information between the Plan and Employer/Plan Sponsor to the following circumstances:
   - To provide coverage under the plan or for modifying, amending, or terminating the Plan. Summary Health Information is information that summarizes participants' claims information from which names and other identifying information have been removed.
   - The Plan may disclose to Employer information on whether an individual is participating in the Plan or has enrolled or dis-enrolled in an insurance option offered by the Plan.
3. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree, by signing a Business Associate Agreement, that the agent agrees to implement reasonable and appropriate privacy and security measures to protect any Protected Health Information received or created to a level that is equivalent to the protections required by HIPAA of the Covered Entity.
4. Not use or disclose the information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer/Plan Sponsor. In addition, you should know that Employer cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Employer from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, any sick leave or PTO program, or workers compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses and disclosures provided for in this Section or the Plan of which it becomes aware. Report to the Privacy Officer any security incident of which it becomes aware.
6. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (including electronic Protected Health Information) created, received, maintained, or transmitted.
7. Make available Protected Health Information (including electronic Protected Health Information) to Plan Participants upon their request of Protected Health Information or electronic Protected Health Information disclosures in accordance with the Privacy Rule.
8. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with the Privacy Rule.
9. Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule and document such disclosures of Protected Health Information.
10. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information or electronic Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA.

11. If feasible, return or destroy all Protected Health Information received from the Plan that Employer/Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

12. Ensure that adequate separation between the Plan and Employer/Plan Sponsor, is established pursuant to the Privacy Rule. Certain employees, equivalently titled employees or classes of employees, or other workforce members under the control of the Employer/Plan Sponsor may be given access to Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan. The specific classes of employees or workforce members who may have access to Protected Health Information are identified in the Employer/Plan Sponsor's separate Privacy Policy. The Plan Administrator or the Privacy Official named in the Employer/Plan Sponsor's Privacy Policy can provide information on the specific employees or classes of employees who have access to Protected Health Information. The list provided in the Privacy Policy shall include every class of employees or other workforce members under the control of the Employer/Plan Sponsor who may receive Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The classes of employees or other workforce members identified in the Employer/Plan Sponsor's Privacy Policy will have access to Protected Health Information only to perform the plan administration functions that the Employer/Plan Sponsor provides for the Plan.

13. The classes of employees or other workforce members identified in the Employer/Plan Sponsor's Privacy Policy will be subject to disciplinary action and sanctions, including termination of employment or affiliation with Employer/Plan Sponsor, for any use or disclosure of Protected Health Information in breach or violation of or noncompliance with the provisions of this Section. Employer/Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant or beneficiary, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

14. The classes of employees or other workforce members identified in the Employer/Plan Sponsor's Privacy Policy will be subject to disciplinary action and sanctions, including termination of employment or affiliation with Employer/Plan Sponsor, for any use or disclosure of Protected Health Information in breach or violation of or noncompliance with the provisions of this Section. Employer/Plan Sponsor will promptly report such breach, violation, or noncompliance as required by law. Provide participants in the Plan with such notice of privacy practices as required pursuant to the Privacy Rule.

15. Provide participants in the Plan with such notice of privacy practices as required pursuant to the Privacy Rule.

L. Your Individual Rights. You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitation, as discussed below. This section describes how you may exercise each individual right.

1. Right to Request Restrictions: You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses and disclosures required by law. You also have the right to request restrictions on your PHI that is disclosed to someone who is involved in your care or the payment for your care, for example, a family member or friend. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief. If you want to exercise this right, your request to the Plan must be in writing. The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed

to restriction. The plan will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

2. Right to Inspect and Copy: With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial by the Privacy Officer. If you want to exercise your right, your request to the Plan must be in writing. Within 90 days of receipt of your request, the Plan will provide you with one of the following:
    - The access or copies you requested
    - A written denial that explains why your request was denied and any rights you may have to have denial reviewed or file a complaint
    - A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

    The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request. You may request an electronic copy of your protected health information. If Plan Sponsor can readily produce it, then it must be supplied to you. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies, if any, must be reasonable, based on the Plan's cost and identify separately the labor for copying PHI (if any).
3. Right to Request Confidential Communication: You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location if you tell us that such alternate communication in necessary to protect you from endangerment. For example, you can ask that the Plan only contact you at work or by mail. To request confidential communications, you must make your request in writing to the HIPAA Privacy Officer as provided in the accompanying PDD Fact Sheet. The Plan will not ask the specific reason for your request. Your request must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your PHI could endanger you.
4. Right to Amend: With certain exceptions, you have a right to request that the Plan amend your health information if it is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the HIPAA Privacy Officer. In addition, you must provide a reason that supports your request. Your request for an amendment may be denied if it is not in writing or does not include a reason to support the request. In addition, your request may be denied if you ask to amend information that:
    - Is not part of the medical information kept by or for the Plan
    - Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment
    - Is not part of the information that you would be permitted to inspect and copy
    - Is not part of a designed record set or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).
    - Is already accurate and complete.

    If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of the following actions:
    - Make the amendment as requested
    - Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint

- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

If your request is denied, you have the right to file a statement of disagreement with us and any future disclosures to the disputed information will include your statement.

5. Right to an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures of your PHI made by the Plan. You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below. You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in the following circumstances:

   - Disclosures for purposes of treatment, payment, or health care operations
   - Disclosures made to you about your own health information
   - Disclosures made pursuant to an authorization
   - Disclosures made to friends or family in your presence or because of an emergency (where disclosure is permitted without authorization)
   - Disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
   - Disclosures incidental to otherwise permissible or required disclosures
   - Disclosures made as part of a "limited data set" (health information that excludes certain identifying information).

   In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. Your request must state the time period through which you want to receive a list of disclosures. The time period may not be longer than six (6) years or commence before the initial effective date stated in this Notice. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plan may charge you the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

6. Right to Obtain a Paper Copy of this Notice: You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

7. Right to Notice of a Breach: You have the right to be notified in the event of any breach that impacts your protected health information. The 2013 Amendments modify this definition by providing that an impermissible use or disclosure of PHI is presumed to be a breach, unless it can be demonstrated that there is a low probability that PHI has been compromised based upon a four-part risk assessment that will be conducted by our HIPAA Privacy or Security Official(s). In the event of any breach, you will be notified at your last known address of the nature and details of such breach and of the corrective action taken.

M. Security Breach. In the event of a security breach, the Plan will comply with regulatory notification requirements. As such, if a breach occurs, the Plan (or a Plan representative) will notify affected individuals of the breach of unsecured PHI and notify the Department of Health and Human Services (as required by regulations). If more than ten individuals are affected and cannot be contacted directly, the Plan will post a general notification of the breach on our web site and notify local print media. If more than 500 individuals are affected by the breach, the Plan will report the breach to well-known media outlets of the breach. The Plan is also required to keep a log of all security breaches and all individuals affected by such breaches.

N. Changes to this Privacy Notice. The plan must abide by the terms of the privacy notice currently in effect. However, the Plan reserves the right to change or revise the terms of its privacy policies, as described

herein at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received as well as health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this SPD, you will be provided with a revised privacy notice by a means consistent with how other employee benefit plan information is disseminated (typically by mail, e-mail, or hand delivery).

O. HIPAA Privacy and Security Officials

1. HIPAA Privacy Officer: The Privacy Officer is an appointed person who is responsible for the development and implementation of the HIPAA Privacy policy and procedures. In some circumstances certain responsibilities may be delegated to a Privacy Contact Person who is designated to provide information and receive complaints regarding HIPAA privacy issues. These positions may change over time and may be designated as the same or different individuals. Contact information for the HIPAA Privacy Officer may be found in the Plan Information section of the PDD Fact Sheet. The PDD Fact Sheet accompanies this PDD Disclosure Document.

2. HIPAA Security Officer: The Security Officer is an appointed person who is responsible for the development and implementation of the Plan's policies and procedures relating to security and the safeguarding of protected health information and electronic protected health information. This position may change over time and may be held by the same individual as the Privacy Officer. Contact information for the HIPAA Privacy Officer may be found in the Plan Information section of the PDD Fact Sheet. The PDD Fact Sheet accompanies this PDD Disclosure Document.

P. Complaints. If you believe your privacy or security rights have been violated or your Plan has not followed its legal obligations under HIPAA, or you wish to file a complaint, you may contact the Privacy Officer and/or the Security Officer. Alternatively, you may file a complaint with the Office for Civil Rights (a division of the Department of Health and Human Services). All inquiries and correspondence regarding the complaint should be forwarded to the HIPAA Privacy Officer. All complaints must be submitted in writing. You should keep a copy of any notices you send to the Plan for your records.

Information on filing a complaint with the Office of Civil Rights may be found on the Department of Health and Human Service website, at http://www.hhs.gov/ocr/contact.html. Complaints filed with the Office of Civil Rights should be sent to the appropriate regional office. A reference list of all regions may also be found on their website. The west coast regional office contact information is as follows:

Office for Civil Rights
U.S. Department of Health & Human Services
50 United Nations Plaza - Room 322
San Francisco, CA 94102
(415) 437-8310 Phone
(415) 437-8329 Fax
(415) 437-8311 TDD

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Plan or with the Office of Civil Rights.

Q. Survival. The provisions of this Privacy Notice shall survive the expiration or termination of the Plan.

R. Compliance with State and Federal Law. Employer/Plan Sponsor shall comply and shall ensure that the Plan complies with HIPAA and other applicable state and federal confidentiality, privacy, and security laws.

S. Interpretation. Any ambiguity in the Plan or this Section or in determining controlling provisions shall be resolved in favor of an interpretation that permits the parties to comply with HIPAA and other federal and state laws and that provides the greatest privacy protections for Protected Health Information. In the event of an inconsistency between the provisions of this Section and mandatory provisions of HIPAA, the HIPAA provisions shall control.

T. Questions. If you have any questions about this Privacy Notice or about our privacy practices, please contact the HIPAA Privacy Officer. Contact information for the Privacy Officer and Security Officer can be found in the Plan Information section of the PDD Fact Sheet. The PDD Fact Sheet accompanies this PDD Disclosure Document.