

SALESFORCE.COM, INC.

CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

Amended and Restated Effective January 1, 2020

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INTRODUCTION

Salesforce.com, inc. (the “Employer”) sponsors and maintains the “salesforce.com, inc. Cafeteria Plan” (the “Plan” or “Cafeteria Plan”) to give eligible employees of the Employer and any affiliates of the Employer that participate in the Plan with the approval of the Employer (collectively, the “Company”) the opportunity to use part of their eligible pay to pay for the cost of certain Employer-sponsored benefits with pre-tax dollars. That is, Plan participants generally are not taxed on the pay used to pay for such benefits. Alternatively, eligible employees may choose to pay for any of the available benefits with after-tax contributions as deductions from their pay. The Cafeteria Plan is part of the salesforce.com, inc. Health and Welfare Plan (the “Health and Welfare Plan”).

The Cafeteria Plan has several components:

- i. Premium Expense Component. The Premium Expense Component allows an eligible employee to pay for his or her share of contributions or premiums for coverage under the Employer’s medical, dental and/or vision plans (collectively, “Health Plan Coverage”) generally on a pre-tax basis. The benefits provided under the Premium Expense Component are called “Premium Expense Benefits.”
- ii. Health Care Spending Account (“HCSA”) Component. The HCSA Component allows an eligible employee to contribute to an HCSA generally on a pre-tax basis and receive reimbursements from such account for qualifying Eligible Medical Expenses (see Q-18).

There are two kinds of HCSAs offered under the HCSA Component:

- (a) a Health Care Flexible Spending Account (“Health Care FSA”) (for eligible employees who *do not* make or receive contributions to a Health Savings Account (as defined below); and
- (b) a Limited Purpose Flexible Spending Account (“Limited Purpose FSA”) (for eligible employees who are enrolled in one of the Employer’s high deductible health plan options (an “HDHP Option”).

The benefits provided under the HCSA Component are called “HCSA Benefits.”

- iii. Dependent Care Spending Account (“DCSA”) Component. The DCSA Component allows an eligible employee to contribute to a DCSA generally on a pre-tax basis and receive reimbursements from such account for qualifying Eligible Employment-Related Expenses (see Q-34). The benefits provided under the DCSA Component are called “DCSA Benefits.”
- iv. Health Savings Account (“HSA”) Component. The HSA Component allows an eligible employee to make contributions to his or her HSA generally on a pre-tax basis. The benefits provided under the HSA Component, which consist solely of the ability to contribute to the HSA on a payroll reduction basis, are called “HSA Benefits.”

This Summary Plan Description document (the “Summary”) was written to give you a summary of the key features of the Plan and each of its components, as in effect on January 1, 2020 (except as otherwise specified in the Summary). Please note, however, that this Summary is a part of, and is meant to be read alongside, the Wrap Summary Plan Description for the Health and Welfare Plan (and the Benefit Booklets incorporated by reference into such document (collectively, the “Wrap SPD”). **Therefore, please read the Wrap SPD and this Summary together carefully, and keep them for future reference.**

Participation in the Plan does not give any Plan participant the right to be retained in the employment of the Employer or its affiliates or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact [salesforce.com, inc.](https://www.salesforce.com), the official administrator of the Plan (the “Plan Administrator”). (See the Wrap SPD for the Plan Administrator’s contact information.)

The Plan Administrator has engaged (the “Third Party Administrator”) to provide day-to-day administration of the HCSA and DCSA Components on behalf of the Plan Administrator, including deciding certain benefit claims and appeals of denied benefit claims under such components. (See the Wrap SPD for the Third Party Administrator’s contact information.)

Q-1. Am I eligible to participate in the Cafeteria Plan?

You may participate in the Cafeteria Plan if you are a U.S. full-time or part-time employee or intern of the Company who is regularly scheduled to work at least 20 hours per week. To be eligible to participate in the HSA Component, however, you also must be an HSA-Eligible Individual (see Q-43).

Notwithstanding the foregoing, you are not eligible to participate in the Cafeteria Plan if you are classified or treated by the Company as a temporary employee, independent contractor, employee of an employment agency or entity other than the Company, leased employee or other non-employee for any period of time, even if you are later determined to have been a common-law employee of the Company during that time.

Eligible employees who actually participate in the Cafeteria Plan are referred to in this Summary as “Participants.”

Q-2. How do I become a Participant?

If you have otherwise satisfied the Plan’s eligibility requirements (see Q-1), you become a Participant by completing the applicable enrollment form (which may be electronic) prescribed by the Plan Administrator (also referred to as the “Election Form”). Under the Election Form, you agree to make contributions from the cash wages or salary otherwise payable to you by the Company to pay for the Plan benefits (“Benefit Plan Options”) that you have elected, on a pre-tax or, if applicable, after-tax, basis. You will be provided with an Election Form when you become eligible to participate in the Cafeteria Plan. You must properly complete the Election Form and submit it to the Plan Administrator in the manner indicated on the Election Form), during one of the election periods described in Q-5 below. You may also enroll in the Plan during a Plan Year (that is, calendar year) if you previously elected not to participate and you experience a change described below that allows you to become a Participant during such year. If that occurs, you must properly complete the applicable election change form (which may be electronic) prescribed by the Plan Administrator (also referred to as the “Election Change Form”) during the applicable Election Change Period described in Q-6 below. In no event can you become a Participant

in the Cafeteria Plan before the date you properly complete and timely submit the Election Form or Election Change Form, as applicable.

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

Plan enrollment also may be accomplished via any other method prescribed by the Plan Administrator, as set forth in the enrollment materials provided by the Plan Administrator (the “Enrollment Materials”).

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

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

- a. The date that you make an election (in accordance with Plan rules) not to participate;
- b. The date you no longer satisfy the eligibility requirements of the Plan or the Benefit Plan Options you have chosen; or
- c. The date that you terminate employment with the Company; or
- d. The date that the Plan or the Benefit Plan Options you have chosen is/are terminated.

If your employment with the Company is terminated during a Plan Year or you otherwise cease to be eligible, your active participation in the Cafeteria Plan will *automatically* cease, and you will not be able to make any more contributions under the Cafeteria Plan. (Note, you or your qualifying family members may be able to continue coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”) with respect to your HCSA (if applicable) for a limited period of time. See the Wrap SPD for information on the availability of any COBRA continuation coverage under the HCSA Component.) If you are rehired within the same Plan Year and are eligible for the Cafeteria Plan (or you become eligible again), you may make new elections, if you are rehired or become eligible again more than 30 calendar days after you terminated employment or lost eligibility (subject to any limitations imposed by the Benefit Plan Option(s)). If you are rehired or again become eligible within 30 calendar days or less of your termination date, your Cafeteria Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan). Notwithstanding the foregoing, a Premium Expense Benefit election will be reinstated only to the extent that Health Plan Coverage is reinstated. Also, an HSA Benefit election will be reinstated only if you are an HSA-Eligible Individual.

Q-4. What are the tax advantages and disadvantages of participating in the Cafeteria Plan?

You may save federal income, state income (in most instances) and Social Security (FICA) taxes by participating in the Cafeteria Plan. Participation in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits that are based on taxable compensation.

Important: The information provided in this Summary is not intended to provide tax advice for any individual’s specific situation. If you have any questions regarding the tax implications of your specific situation, please consult your qualified tax advisor.

Q-5. What are the election periods for entering the Cafeteria Plan?

The Cafeteria Plan basically has three election periods: (i) the “Initial Election Period,” (ii) the “Annual Election Period,” and (iii) the “Election Change Period,” which is the applicable period following the date you have a Status Event described in Q-6 below. The following is a summary of the Initial Election Period and the Annual Election Period.

Q-5a. What is the Initial Election Period?

If you want to participate in the Cafeteria Plan when you are first hired as an eligible employee, you must enroll during the “Initial Election Period” described in the Enrollment Materials you will receive. If you make an election during the Initial Election Period, your participation in this Cafeteria Plan will begin on the later of your eligibility date or the first pay period coinciding with or next following the date that your election is received by the Plan Administrator, or as soon as administratively practicable thereafter. The effective date of coverage under the Benefit Plan Options elected will be the date established in the governing documents of the Benefit Plan Options. The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Status Event described in Q-6 below and your new election is consistent with that event, as determined by the Plan Administrator in its discretion.

If you do not make an election during the Initial Election Period, you will be deemed to have elected not to participate in this Cafeteria Plan for the remainder of the Plan Year. Failure to make an election under this Cafeteria Plan generally results in no coverage under the Benefit Plan Options; however, the Employer may provide coverage under certain Benefit Plan Options automatically. These automatic benefits are called “Default Benefits.” Any Default Benefit provided by the Employer will be identified in the Enrollment Materials. In addition, your share of the contributions or premiums for such Default Benefits may be automatically withdrawn from your pay. You will be notified in the Enrollment Materials whether there will be a corresponding contribution required for such benefits.

Q-5b. What is the Annual Election Period?

The Cafeteria Plan also has an “Annual Election Period” during which you may enroll in the Plan if you otherwise satisfy the applicable eligibility requirements. The Annual Election Period will be identified in the Enrollment Materials distributed to you prior to the Annual Election Period.

If you fail to properly complete the Election Form during the Annual Election Period, you will be deemed to have elected not to participate in the Cafeteria Plan for the next Plan Year, except as otherwise specified in the Enrollment Materials.

The election(s) that you make (or are deemed to have made, if applicable) during the Annual Election Period will be effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless a Status Event described in Q-6 below occurs and your new election is consistent with that event, as determined by the Plan Administrator in its discretion.

Q-6. Under what circumstances can I change my election(s) during the Plan Year?

With the exception of HSA Benefits (for which prospective election changes generally are allowable), you cannot change your election(s) under the Cafeteria Plan during the Plan Year. There are, however, a few exceptions.

First, your election will automatically terminate if you terminate employment with the Company or otherwise lose eligibility under the Cafeteria Plan or the Benefit Plan Options that you have chosen.

Second, you may be able to voluntarily revoke your existing election and make a new election for the remainder of the Plan Year if you satisfy the following conditions (prescribed by federal law), as determined by the Plan Administrator in its discretion:

- a. You experience a “Change in Status Event” that affects your eligibility under the Cafeteria Plan and/or Benefit Plan Option; or
- b. You experience a significant Cost or Coverage Change; or
- c. Another event specified in Appendix II - Election Changes occurs; and
- d. Your new election is consistent with the applicable event permitting the new election (the “Status Event”); and
- e. You timely complete and properly submit an Election Change Form within the Election Change Period described in Appendix II - Election Changes, if applicable, in accordance with Plan rules.

The Status Events recognized by the Plan, and the rules surrounding election changes in the event a Status Event occurs are described in Appendix II - Election Changes.

Third, the Plan Administrator may reduce your compensation reductions (and increase your taxable pay) during the Plan Year if you are a “key employee” or “highly compensated individual” (as such terms are defined by the applicable provisions of the Internal Revenue Code (the “Code”)), if necessary, to prevent the Plan and/or any Plan component from becoming discriminatory within the meaning of the applicable Code provisions.

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

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

As noted earlier, you may be given a choice to pay for any Benefit Plan Options that you elect with pre-tax or after-tax contributions. The Enrollment Materials you receive will indicate whether you have an option to choose to pay with pre-tax or after-tax contributions.

When you elect a Benefit Plan Option under the Plan for a Plan Year, an amount equal to your share of the annual cost of those Benefit Plan Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from your eligible pay each pay period after the effective date of your election. For purposes of the Plan, your “eligible pay” means the cash wages or salary otherwise payable to you by the Company. If you have chosen to use pre-tax contributions (or it is a Plan requirement), the deduction is made before federal income taxes and (in most instances) state income taxes are withheld.

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

Q-8. What happens to my participation under the Cafeteria Plan if I take a Company-approved leave of absence?

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Plan Options) during a Company-approved leave of absence. The specific election changes that you can make under the Cafeteria Plan following a leave of absence are described in Appendix II - Election Changes and the rules regarding coverage under the Benefit Plan Options during a leave of absence will be described in the related Benefit Booklets for those options. If there is a conflict between Appendix II - Election Changes/Benefit Booklets and this Q-8, Appendix II or Benefit Booklet, whichever is applicable, will control.

- a. If you go on a qualifying leave under the Family and Medical Leave Act of 1993 ("FMLA"), then to the extent required by the FMLA, the Employer will continue to maintain your Health Plan Coverage, if any, on the same terms and conditions as though you were still an active eligible employee (e.g., the Company will continue to pay its share of the contributions or premiums to the extent you opt to continue Health Plan Coverage and you pay your share of such contributions or premiums).
- b. The Company may elect to continue all Health Plan Coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions or premiums by the method normally used during any paid leave.
- c. In the event of an unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your Health Plan Coverage, you may pay your share of the contributions or premiums in one of the following ways:
 - i. With after-tax contributions while you are on leave.
 - ii. You may pre-pay all or a portion of your share of the contributions or premiums for the expected duration of the leave with pre-tax contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you. However, pre-payments of pre-tax contributions may not be utilized to fund any coverage during the next Plan Year.
 - iii. By other arrangements agreed upon between you and the Plan Administrator (for example, the Company may pay the contributions or premiums for coverage during the leave and withhold applicable amounts from your compensation upon your return from leave).

The payment options provided by the Plan Administrator will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence and will be applied uniformly to all Participants. Alternatively, the Employer may require all Participants to continue any Health Plan Coverage during the leave. If so, you may elect to discontinue your share of the required contributions or premiums until you return from leave. Upon return from leave, you will be required to repay the contributions not paid during the leave in a manner agreed upon with the Plan Administrator.

- d. If your Health Plan Coverage, if any, ceases while on FMLA leave (e.g., for non-payment of required contributions or premiums), you will be permitted to re-enter the Cafeteria Plan and the applicable Benefit Plan Options upon return from such leave on the same basis as you were participating in such options prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plan Options providing Health Plan Coverage may be automatically reinstated provided that coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.
- e. The Employer may, on a uniform and consistent basis, continue your Health Plan Coverage, if any, for the duration of the leave following your failure to pay the required contributions or premiums. Upon return from leave, you will be required to repay the applicable contributions or premiums in a manner agreed upon by you and the Employer.
- f. If you are commencing or returning from unpaid FMLA leave, your election under the Cafeteria Plan for Benefit Plan Options providing non-Health Plan Coverage will be treated in the same manner that elections for non-health Benefit Plan Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.
- g. If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility for the Plan or a Benefit Plan Option in which you are enrolled, then you will continue to participate and the contributions or premiums due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator in its discretion. If you go on an unpaid leave that affects eligibility under the Plan or a Benefit Plan Option in which you are enrolled, the election change rules described in the Summary will apply. The Plan Administrator will determine in its discretion whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-9. Can the Cafeteria Plan be amended and/or terminated?

Yes, although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the Plan or any of its components at any time for any reason. Any Plan amendments and/or terminations will be approved by the Employer in accordance with its normal procedures for transacting business.

Q-10. What happens if my request for a benefit under the Cafeteria Plan is denied?

Please refer to Appendix I for a detailed summary of the Plan's claims and appeal procedures that must be followed with respect to any claim for a Plan benefit.

Q-11. What are Premium Expense Benefits?

If you elect Premium Expense Benefits, as described earlier, you will be able to pay for your share of contributions or premiums for Health Plan Coverage via payroll deductions generally on a pre-tax basis (that is, before federal income, state income (in most instances) and Social Security taxes are taken out). (See Q-4 for more information.)

Q-12. What are HCSA Benefits?

If you elect HCSA Benefits, as described earlier, you will be able to provide a source of pre-tax funds to reimburse yourself for qualifying Eligible Medical Expenses (see Q-18). That is, the amount you elect to contribute to your HCSA for a Plan Year will be pro-rated and deducted from your eligible pay each payroll period during the Plan Year generally on a pre-tax basis - that is, before federal income, state income (in most instances) and Social Security taxes are taken out. (See Q-4 for more information.) These payroll deductions will appear as a credit to your HCSA.

The amounts contributed to your HCSA for a Plan Year may be used to reimburse yourself for qualifying Eligible Medical Expenses that have been incurred by you and/or your Spouse (if you are married) and/or other Eligible Dependents (see Q-19) during the Plan Year while coverage is in effect and that are not reimbursed elsewhere. In the event that a qualifying expense is eligible for reimbursement under both a Limited Purpose FSA and HSA, you may seek reimbursement from either the Limited Purpose FSA or HSA, if applicable, but not both.

Q-13. What is my HCSA?

If you elect HCSA Benefits, the Plan Administrator will establish either a Health Care FSA or Limited Purpose FSA, as you elect, to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account will be established; it is merely a bookkeeping account. HCSA Benefits are paid as needed from the Company's general assets and do not bear any interest or any other earnings.

Note: if you elect HCSA Benefits, you cannot also elect HSA Benefits or otherwise make contributions to an HSA unless you elect the Limited Purpose FSA option. If you elect the Health Care FSA option, your Spouse (see Q-19), if you are married, and other Eligible Dependents (see Q-19), also will be ineligible to make any HSA contributions. Also, see Q-27 regarding the impact of the HCSA Component's carryover provision on HSA eligibility.

Q-14. What are the minimum and maximum HCSA Benefits that I may elect under the Plan?

You may elect to contribute from \$20 to \$2,550 annually to either the Health Care FSA or Limited Purpose FSA, subject to the limitations imposed by applicable law and Internal Revenue Service ("IRS") guidance.

Any change in your HCSA election, if permitted, also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only and by a method determined by the Plan Administrator that is in accordance with applicable law and IRS guidance. The Plan Administrator will notify you of the applicable method when you make your election change.

Q-15. How are HCSA Benefits paid for under this Plan?

When you complete the Election Form, you specify the amount of annual HCSA reimbursement you wish to pay for with pre-tax contributions. After the effective date of your enrollment, each paycheck will be reduced by an amount equal to pro-rata share of your annual contribution amount (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Q-16. What amounts will be available for HCSA reimbursement at any particular time during the Plan Year?

So long as your coverage is in effect, the full amount of HCSA coverage that you have elected for the Plan Year, reduced by the amount of previous HCSA reimbursements received during the Plan Year, will be available to reimburse you for qualifying Eligible Medical Expenses incurred during the Plan Year, without regard to how much you have contributed at the time of submission of the qualifying claim. The amount of HCSA coverage that is available to you also will be increased by the amount of any carryovers (see Q-27).

Note, only reasonable quantities of prescribed over-the-counter drugs will be reimbursed from your HCSA, as applicable, in a single calendar month, even if the drugs otherwise meet the requirements for reimbursement. Stockpiling is not permitted.

Q-17. How do I make a claim for reimbursement of qualifying Eligible Medical Expenses under the HCSA Component?

You have several reimbursement options for your HCSA. You can complete and submit a written claim form for reimbursement (“Pay Me Back Claim Form”), you can request payment directly to your health plan provider (“Pay My Provider”), claims may be submitted automatically from your health plan provider, you can use the myCYC mobile app from the Third Party Administrator to file claims, or you can use an electronic payment card (“Health Care Card”) to pay the expense. In order to be eligible for the Health Care Card, you must agree to abide by the terms and conditions of the Health Care Card Program (the “Program”) as set forth herein and in the Health Care Cardholder Agreement (the “Cardholder Agreement”), including any fees applicable to participate in the program, limitations as to card usage, the Plan’s right to withhold and offset for ineligible claims, etc.).

Important: You will have 120 calendar days after the end of the Plan Year of coverage in which to submit a claim for reimbursement for qualifying Eligible Medical Expenses incurred during such period of coverage; however, if you cease to be a Participant in the HCSA Component mid-Plan Year, you will only have 90 calendar days after the date you ceased to be a Participant in which to submit a claim for reimbursement for qualifying Eligible Medical Expenses incurred before the date you ceased to be a Participant. The applicable 120-day or 90-day period is referred to in this Summary as the “Run-Out Period” for the HCSA Component.

The following is a summary of how the various reimbursement options for your HCSA work. If you have any questions about the options, please contact the Third Party Administrator.

Pay Me Back Claim: When you incur a qualifying Eligible Medical Expense, you may file a claim with the Third Party Administrator by completing and submitting a Pay Me Back Claim Form. You may

obtain a Pay Me Back Claim Form at www.connectyourcare.com. Simply enter your user name and password, or select First Time User to complete the online registration process to access your account online. You must include with your Pay Me Back Claim Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

- a. The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the receipt must indicate the Rx number or, the name of the drug and a copy of the prescription recognized under applicable state law;
- b. The date the expense was incurred; and
- c. The amount of the expense.

The Third Party Administrator will process the claim once it receives the Pay Me Back Claim Form and required substantiation documentation from you. Reimbursement of expenses that are determined to be qualifying Eligible Medical Expenses will be made as soon as possible after the Third Party Administrator receives the claim and processes it. If the expense is determined to not be a qualifying “Eligible Medical Expense,” you will receive notification of this determination.

Pay My Provider: You can request that payment of a qualifying Eligible Medical Expense be made directly from your HCSA and sent directly to your provider.

Automatic Rollover Claims: If offered by the Employer, a claim can be submitted on your behalf by your health plan provider, based on Eligible Medical Expenses related to health care claims processed by that health plan provider. Please contact the Third Party Administrator for more information.

myCYC Mobile App: If you have a Smartphone, you may use the myCYC mobile app from the Third Party Administrator to file claims. To use myCYC, you must download the free app from the Third Party Administrator’s website at <https://www.connectyourcare.com/mobile-apps/>, and follow the applicable instructions.

Health Care Card: The Health Care Card allows you to pay for qualifying Eligible Medical Expenses at the time that you incur the expense. Here is how the Health Care Card works.

- a. *You must make an election to use the card by activating it.* In order to be eligible for the Health Care Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Cardholder Agreement, including any fees applicable to participate in the Program, limitations as to card usage, the Plan’s right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period, as applicable. The card may be turned off if you do not provide substantiation when requested for card transactions that are not able to be electronically adjudicated. The Cardholder Agreement is part of the terms and conditions of the Plan and this Summary.
- b. *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment with the Company or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period. (See the Wrap SPD for information on the availability of any COBRA continuation coverage under the HCSA.)

- c. *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your HCSA will only be used for qualifying Eligible Medical Expenses incurred by you and/or your Spouse (if you are married) and other Eligible Dependents (see Q-19) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.
- d. *HCSA reimbursement under the card is limited to certain providers, pharmacies, and merchants.* Use of the card for eligible HCSA expenses is limited to merchants who are health care providers or merchants that have inventory systems that meet specific IRS requirements. The card also may be used at select pharmacies. In certain cases, the Third Party Administrator may ask you to provide substantiation of the items or services purchased. For more information on where you may use the card, please contact the Third Party Administrator.
- e. *You swipe the card at the health care provider like you do any other credit or debit card.* When you incur a qualifying Eligible Medical Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the HCSA (or as otherwise limited by the Program) at that time you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the HCSA is being made is a qualifying Eligible Medical Expense and that you have not been reimbursed for that expense from any other source nor will you seek reimbursement for that expense from another source.
- f. *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the health care provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:
 - i. The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the receipt must indicate the Rx number or, the name of the drug and a copy of the prescription recognized under applicable state law;
 - ii. The date the expense was incurred and who incurred the expense; and
 - iii. The amount of the expense.

Information may be collected from a number of sources regarding the services you received or products you purchased using the card, in order to determine if your HCSA was used to pay for qualifying Eligible Medical Expenses. If the information available indicates this might not be an eligible expense, or if information is not sufficient or available, you will be required to submit a detailed receipt, along with a Card Use Verification Form, to show that the card was used for eligible expenses. Card Use Verification Forms are provided along with your monthly HCSA statement. For more information on amounts not verified, please see the Review Your Options section of your account on-line at www.connectyourcare.com.

- g. *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation within 90 days, as requested by the Third Party Administrator, you must repay the unsubstantiated expense, and/or be subject to other collection policies, in accordance with applicable IRS guidance. If you do not repay the applicable amount within the applicable time

period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against any future eligible claims under the HCSA. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement) or the remaining unpaid amount will be included in your gross income as taxable “appeals,” as permitted by applicable law.

- h. *You can use any of the available reimbursement options under the HCSA Component.* You have the choice as to how to submit your eligible claims. If you elect not to use the Health Care Card, you may also submit qualifying claims using any of the other reimbursement options described above. Claims for which the Health Care Card has been used cannot be submitted via any of the other reimbursement options that are otherwise available.

Q-18. What is an Eligible Medical Expense that may be reimbursed from the HCSA?

The Eligible Medical Expenses that may be reimbursed depends on the type of HCSA option that you have (either the Health Care FSA or Limited Purpose FSA), as described below.

Health Care FSA Option

If you are covered under the Health Care FSA option, an “Eligible Medical Expense” means an expense that has been incurred by you, your Spouse (if married) and/or your other Eligible Dependents that satisfies the following conditions:

- a. The expense is for “medical care” as defined in Code Section 213(d);
- b. The expense has not been reimbursed by any other sources, and reimbursement for the expense will not be sought from any other source; and
- c. The expense is otherwise reimbursable under the HCSA (per IRS regulations).

(See Q-19 below for information on who qualifies as your Spouse and other Eligible Dependent for purposes of the HCSA.)

Code Section 213(d) generally defines “medical care” as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. Not every health-related expense you or your Eligible Dependents incur constitutes an expense for “medical care,” however. For example, an expense is not for “medical care,” as that term is defined by the Code, if it is merely for the beneficial health of you and/or your Eligible Dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury, or birth defect.

In addition, certain expenses set forth below that might otherwise constitute “medical care” as defined by the Code are not reimbursable under any HCSA (per IRS regulations):

- a. Health insurance premiums;

- b. Expenses incurred for qualified long-term care services;
- c. Expenses for a medicine or drug unless such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin; and
- d. Any other expenses that are specifically excluded by the Employer.

Thus, for example, over-the-counter (“OTC”) medicines or drugs, such as aspirin, antihistamines and cough syrup must be prescribed in order to qualify as an Eligible Medical Expense; to be reimbursed for an OTC medicine or drug (other than insulin), you must provide the Third Party Administrator with substantiation documentation that the item was prescribed (see Q-17). Also, as described earlier, only reasonable quantities of any prescribed OTC medicines or drugs will be reimbursable from your HCSA in a single calendar month.

For a list of Eligible Medical Expenses that are reimbursable under the Health Care FSA option, go to www.connectyourcare.com and enter your user name and password.

Limited Purpose FSA Option

According to the rules in Code Section 223 (applicable to HSAs), you will not be able to make/receive tax-favored contributions to your HSA if you participate in an HCSA that reimburses Eligible Medical Expenses that are reimbursable from a general Health Care FSA (as described under the “Health Care FSA Option” section above). You may, however, be eligible to make/receive tax-favored contributions to an HSA and participate in an HCSA if the HCSA is a Limited Purpose FSA.

If you have coverage under the Limited Purpose FSA option, then only otherwise qualifying dental care (excluding premiums), vision care (excluding premiums), and “preventive care” expenses incurred by you, your Spouse (if you are married) and/or your other Eligible Dependents may be reimbursed from the Limited Purpose FSA. “Preventive care” is defined in accordance with the applicable rules under Code Section 223(c)(2)(C). Once the deductible under the HDHP has been met and you provide the Third Party Administrator with the required documentation and/or information substantiating that the deductible has been met, then all Eligible Medical Expenses that are incurred by you and your Eligible Dependents after the deductible has been met and that are otherwise reimbursable under the Health Care FSA rules above may be reimbursed under the Limited Purpose FSA.

For a list of Eligible Medical Expenses that are reimbursable under the Limited Purpose FSA option, go to www.connectyourcare.com and enter your user name and password.

Q-19. Who qualifies as your Eligible Dependent?

For purposes of Health Plan Coverage (to the extent funded under the Premium Expense Component) and for purposes of the HCSA Component, “Eligible Dependent” means:

- a. Your Spouse (that is, an individual who is treated as your spouse under the Code);
- b. Your biological, step, eligible foster or legally adopted child (including a child placed with you for adoption) who has not attained age 27 as of the end of the Plan Year of coverage, even if you cannot claim such child as your tax dependent under the Code for such Plan Year; or

- c. Your tax dependent under the Code for the Plan Year of coverage, except that an individual's status as an Eligible Dependent is determined without regard to the gross income limitation for any qualifying relative and certain other provisions of the Code's definition. If you need help determining this, see IRS Publications 17 and 501, which are available through the IRS' website at www.irs.gov.

For general information on who will likely qualify as your Eligible Dependent, you should contact the Third Party Administrator (see the Wrap SPD for the applicable contact information). However, because the determination of whether an individual satisfies the definition of an Eligible Dependent turns on facts solely within your knowledge, the Third Party Administrator, the Plan Administrator or the Company cannot make this determination for you. It can be complex to determine whether an individual satisfies the definition of an Eligible Dependent. Thus, you may wish to consult a qualified tax professional for advice on your personal situation.

Q-20. When must qualifying Eligible Medical Expenses be incurred in order to receive reimbursement?

Qualifying Eligible Medical Expenses must be incurred *during* the Plan Year and while you are covered under the HCSA Component. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an Eligible Medical Expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. Except as provided below, you may not be reimbursed for any Eligible Medical Expenses arising before the HCSA becomes effective, before your Election Form becomes effective, or for any such expenses incurred after the close of the Plan Year, or, after a separation from service or other loss of eligibility or coverage under the HCSA (except for qualifying Eligible Medical Expenses incurred during an applicable COBRA continuation period).

You may not use any HCSA amounts to reimburse any qualifying Eligible Employment-Related Expenses and DCSA amounts may not be used to reimburse qualifying Eligible Medical Expenses.

Q-21. What if the qualifying Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for HCSA reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual qualifying Eligible Medical Expenses you have incurred and the annual coverage level you have elected. Any amount allocated to a HCSA shall be forfeited by the Participant and restored to the Company if it has not been applied to provide reimbursement for qualifying Eligible Medical Expenses that are incurred during the Plan Year and submitted for reimbursement by the end of the applicable Run-Out Period (see Q-17). This is the so-called "use-it-or-lose-it" rule under applicable tax laws. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable law and IRS or Department of Labor ("DOL") guidance (in the Plan Administrator's sole discretion). (However, see Q-27 for information on the effect of the HCSA Component's carryover provision.)

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

You will have the right to a full and fair review process. You must refer to Appendix I for a detailed summary of the Plan's claims procedures that must be followed in order to make a claim for benefits under the HCSA and to appeal any denied claim.

Q-23. What happens to unclaimed HCSA reimbursements?

Any HCSA reimbursement benefit payments that have been approved and remain unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year immediately following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited. Any amounts so forfeited will be applied in a manner that is consistent with applicable law and IRS guidance (in the Plan Administrator's sole discretion).

Q-24. What is continuation coverage?

COBRA

COBRA continuation coverage is a temporary extension of group health plan coverage that would otherwise end because of a life event known as a "qualifying event." For information on the availability of any COBRA continuation coverage under the HCSA Component, including when it may become available to you and your qualifying family members, and what you need to do to protect the right to receive it, please refer to the Wrap SPD.

USERRA

Continuation and reinstatement rights also may be available if you are absent from employment with the Company due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). For information on the availability of any USERRA continuation coverage, please refer to the Wrap SPD.

If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

Q-25. Will my protected health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans, such as the HCSA Component, and business associates of group health plans, such as the Third Party Administrator for the HCSA Component, are required to take certain steps to ensure that certain "protected health information" is kept confidential in accordance with the requirements of HIPAA. You will receive separate notices from the Employer (or applicable medical plan insurers) that outlines the group health plans' or insurers' health privacy policies, as applicable, including with regard to electronic protected health information.

Q-26. How long will the HCSA Component remain in effect?

Although the Employer expects to maintain the HCSA Component indefinitely, it has the right to modify or terminate the Plan or any of its components, such as the HCSA Component, at any time and for any reason.

Q-27. What are HCSA carryovers?

You may carry over up to \$500 of unused amounts remaining in your HCSA at the end of a Plan Year to be used for qualifying Eligible Medical Expenses incurred during the next Plan Year. No more than \$500 of your unused HCSA amount for a Plan Year may be carried over for use in the next Plan Year.

Example: At the end of the 2019 Plan Year, you remain a Participant in the HCSA and your unused HCSA amount is \$850. You may carry over up to \$500 to reimburse qualifying Eligible Medical Expenses incurred during the 2020 Plan Year. However, the entire \$850 is also available during the applicable Run-Out Period (that is, the 120-day period immediately following the end of the 2019 Plan Year) to reimburse qualifying Eligible Medical Expenses that have been incurred during the 2019 Plan Year and have not yet been reimbursed. Assume that, during the Run-Out Period, you submit and are reimbursed for 2019 Plan Year qualifying Eligible Medical Expenses of \$400. This leaves you with a carryover of \$450 (\$850-\$400), which can be used for qualifying Eligible Medical Expenses incurred during the 2020 Plan Year. On the other hand, if you do not submit the \$400 in 2019 Plan Year qualifying Eligible Medical Expenses during the Run-Out Period, then you will be able to carryover the maximum permitted amount of \$500 to the 2020 Plan Year and the remaining \$350 will be forfeited.

Any carryovers may not be cashed out or converted to any other benefit, and they will not count toward the maximum dollar limit on annual salary reductions under the HCSA.

Example: Assume that for the 2019 Plan Year, you elect the maximum HCSA Benefit amount permitted under the Plan. Your election will not affect any carryover that you may have, and you can also carry over the maximum permitted amount of \$500 from the 2019 Plan Year to the 2020 Plan Year.

If you are otherwise eligible for the HCSA for a Plan Year but you do not make an HCSA election for that Plan Year, you may still use any carryovers from the preceding Plan Year for current or preceding Plan Year qualifying Eligible Medical Expenses (in accordance with the terms of the Plan). However, you must be a Participant in the HCSA as of the last day of the Plan Year to benefit from the carryover. Termination of employment and cessation of eligibility generally will result in a loss of carryover eligibility unless a COBRA continuation coverage election is made (see the Wrap SPD for more information on any COBRA continuation coverage availability).

Under IRS rules, if you carry over any unused HCSA amounts to a Health Care FSA, you (and any other individual whose qualifying Eligible Medical Expenses can be reimbursed by your Health Care FSA) **cannot** contribute to an HSA during the **entire** next Plan Year. Thus, if you have any unused amounts remaining in a Health Care FSA at the end of a Plan Year that are available for carryover and you elect the Employer's HDHP medical plan option for the next Plan Year, the unused amounts will be automatically carried over to a Limited Purpose FSA on your behalf. However, you may continue to submit claims for qualifying Eligible Medical Expenses incurred during the preceding Plan Year until the end of the Run-Out Period, to be reimbursed from your available Health Care FSA for the preceding Plan Year.

For more information about carryovers and how they work, please contact the Third Party Administrator.

Q-28. Will I be taxed on the HCSA Benefits that I receive under the Plan?

You generally will not be taxed on your HCSA Benefits, up to the limits specified above. However, the Plan Administrator or Company cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Eligible Medical Expenses must meet the definition of "medical care," as defined in the Code, as well as other requirements. Ultimately, it is your responsibility to determine whether any reimbursement under your HCSA constitutes qualifying Eligible

Medical Expenses that qualify for income tax exclusion. If you have any questions about which expenses are or are not likely to be reimbursable from your HCSA, please contact the Third Party Administrator. However, please remember that the Third Party Administrator, the Plan Administrator and/or the Company may not provide any legal advice. If you need an answer upon which you may rely, you should consult with a tax professional.

Q-29. What are DCSA Benefits?

If you elect DCSA Benefits, as described earlier, you will be able to provide a source of pre-tax funds to reimburse yourself for qualifying Eligible Employment-Related Expenses (see Q-34). That is, the amount you elect to contribute to your DCSA for a Plan Year will be pro-rated and deducted from your eligible pay each payroll period during the Plan Year generally on a pre-tax basis - that is, before federal income, state income (in most instances) and Social Security taxes are taken out. (See Q-4 for more information.) These payroll deductions will appear as a credit to your DCSA.

The amounts contributed to your DCSA for a Plan Year may be used to reimburse yourself for qualifying Eligible Employment-Related Expenses that have been incurred by you or your Spouse (if you are married) during the Plan Year while coverage is in effect (and during its Grace Period, if applicable) and that are not reimbursed elsewhere.

Q-30. What is my DCSA?

If you elect DCSA Benefits, the Plan Administrator will establish a DCSA to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account will be established; it is merely a bookkeeping account. DCSA Benefits are paid as needed from the Company's general assets and do not bear any interest or any other earnings.

Q-31. What are the minimum and maximum DCSA Benefits that I may elect under the Plan?

You may choose any amount of Eligible Employment-Related Expense reimbursement that you wish under the DCSA, subject to a minimum reimbursement amount of \$20 and a maximum reimbursement amount of \$2,500. Under your Election Form, you agree to pay via payroll deductions the annual DCSA contribution equal to the coverage level that you have elected (for example, if you elect \$2,500 in DCSA Benefits, you will pay for such benefits with a \$2,500 reduction of your eligible pay).

However, the amount of Eligible Employment-Related Expense reimbursement that you elect for a Plan Year (that is, calendar year) cannot exceed the maximum amount that you have reason to believe will be excludable from your income under Code Section 129 when your election is made, as described below.

The amount of reimbursement that you may receive under the DCSA on a tax-free basis during a calendar year cannot exceed the lesser of your earned income (as defined in Code Section 32) or, if you are married, your Spouse's earned income), as described below, for the year.

As noted earlier, your "Spouse" means an individual who is treated as your spouse under the Code. However, for purposes of the DCSA Component, the term "Spouse" does not include (a) an individual who is legally separated from you under a divorce or separate maintenance decree, or (b) an individual who is married to you and files a separate federal income tax return, where (i) you maintain a household that constitutes a Qualifying Individual's principal place of abode for more than half of the taxable year,

(ii) you furnish more than half of the cost of maintaining such household, and (iii) during the last 6 months of such year, the individual is not a member of such household.

Your Spouse will be deemed to have earned income of \$250 if you have one Qualifying Individual (see Q-34) and \$500 if you have two or more Qualifying Individuals, for each month in which your Spouse is:

- a. Physically or mentally incapable of caring for himself or herself (provided that you and your Spouse have the same principal place of abode for more than half of that year); or
- b. A full-time student (as defined by Code Section 21).

Note, if you are married and your Spouse also participates in a DCSA, the maximum amount that you and your Spouse together can exclude from income is \$5,000.

Q-32. How do I pay for DCSA Benefits?

When you complete the Election Form, you specify the amount of annual DCSA reimbursement you wish to pay with pre-tax contributions. After the effective date of your enrollment, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution amount (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Q-33. What amounts will be available for DCSA reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of qualifying Eligible Employment-Related Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCSA at the time your claim is paid, reduced by the amount of previous DCSA reimbursements paid to you during the Plan Year. You may also be able to be reimbursed from unused amounts remaining in your DCSA at the end of the Plan Year for qualifying Eligible Employment-Related Expenses incurred during a Grace Period following the end of the Plan Year. (See Q-36 for more information on the availability of any Grace Period.)

Q-34. What is an "Eligible Employment-Related Expense" for which I can claim a reimbursement from my DCSA?

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

- a. The expense is incurred for qualifying services rendered after the date of your election to receive DCSA Benefits and during the calendar year to which the election applies and while coverage is in effect.
- b. Each individual for whom you incur the expense is a "Qualifying Individual." A Qualifying Individual is:
 - (i) An individual age 12 or under who is your "qualifying child" as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g. a niece, nephew,

grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her support for the year.

(ii) Your Spouse or other tax dependent under the Code who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year (note, for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition).

Note: Under a special rule under the Code for children of divorced or separated parents, generally a child is a Qualifying Individual of the custodial parent when the non-custodial parent is entitled to claim the dependency exemption for the child. Please contact the Third Party Administrator for more information.

- c. The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services attributable in part to the care of the Qualifying Individual, and is incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or actively looking for work. There is an exception: If your Spouse is not working when the expense is incurred, he or she must be a full-time student or be physically or mentally incapable of self-care. The expense can also be incurred while you are working and your Spouse is sleeping (or vice versa), if one of you works during the day and the other works at night and sleeps during the day. Expenses for overnight stays or overnight camps are not eligible. Tuition expenses for kindergarten (or above) also do not qualify.
- d. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual other than an individual under age 13 who is your qualifying child under the Code, then such Qualifying Individual must regularly spend at least 8 hours per day in your household.
- e. If the expense is incurred for services provided by a dependent care center (i.e., a facility, including a day camp, that provides care for more than six (6) individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- f. The person who provided the care was not your Spouse, a parent of your under age 13 qualifying child (for example, a former spouse who is the child's noncustodial parent), or an individual for whom you or your Spouse is entitled to a personal tax exemption under Code Section 151(c). If your child provided the care, then he or she must be at least age 19 at the end of the calendar year in which the expense is incurred.
- g. You generally must supply the name, address and taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.
- h. No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCSA.

You are encouraged to consult your personal tax advisor or IRS Publication 17 “Your Federal Income Tax” for further guidance as to what is or is not an Eligible Employment-Related Expense if you have any doubts.

Q-35. How do I receive reimbursement under the DCSA?

Under the DCSA Component, you have various reimbursement options. You can complete and submit a written Claim Form for reimbursement (“Pay Me Back Claim”), you can request payment directly to your dependent care provider (“Pay My Provider”) or you can use the myCYC mobile app from the Third Party Administrator to file claims.

Important: You will have 120 calendar days after the end of the Plan Year of coverage in which to submit a claim for reimbursement for qualifying Eligible Employment-Related Expenses incurred such period of coverage; however, if you cease to be a Participant in the DCSA Component mid-Plan Year, you will only have 90 calendar days after the date you ceased to be a Participant in which to submit a claim for reimbursement for qualifying Eligible Employment-Related Expenses incurred before the date you ceased to be a Participant. The applicable 120-day or 90-day period is referred to below as the “Run-Out Period” for the DCSA Component.

The following is a summary of how the various reimbursement options for your DCSA work. If you have any questions about the options, please contact the Third Party Administrator.

Pay Me Back Claim: When you incur a qualifying Eligible Employment-Related Expense, you may file a claim with the Third Party Administrator by completing and submitting a Pay Me Back Claim Form. You may obtain a Pay Me Back Claim Form at www.connectyourcare.com. Simply enter your user name and password, or select First Time User to complete the online registration process to access your account online. You must include with your Pay Me Back Claim Form a written statement from an independent third party (e.g., a receipt, etc.) associated with each expense that indicates the following:

- a. The date(s) the expense was incurred;
- b. The nature of the expense (e.g., what type of service was provided and the name of the Qualifying Individual for whom the expense was incurred); and
- c. The amount of the expense.

The Third Party Administrator will process the claim once it receives the Pay Me Back Claim Form and required substantiation documentation from you. Reimbursement for expenses that are determined to be qualifying Eligible Employment-Related Expenses will be made as soon as possible after the Third Party Administrator receives the claim and processes it. If the expense is determined to not be a qualifying “Eligible Employment-Related Expense,” you will receive notification of this determination.

Pay My Provider: You can request that payment of a qualifying Eligible Employment-Related Expense be made directly from your DCSA and sent directly to your provider.

myCYC Mobile App: If you have a Smartphone, you may use the myCYC mobile app from the Third Party Administrator to file claims. To use myCYC, you must download the free app from the Third Party Administrator’s website at <https://www.connectyourcare.com/mobile-apps/>, and follow the applicable instructions.

If your claim was for an amount that was more than your current DCSA balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate.

You must incur the expense in order to receive payment. “Incurred” means the service has been provided without regard to whether you have paid for the service. Payments for advance services are not reimbursable because they have not yet been incurred. For example, Employee A pays the monthly day care fee on January 1 and then submits a copy of the receipt on January 3. The expense for the entire month is not reimbursable until the services for that month have been performed. In addition, you must certify with each claim that you have not been reimbursed for the expense(s) from any other source and you will not seek reimbursement from any other source.

Q-36. When must the qualifying Eligible Employment-Related Expenses be incurred in order to receive reimbursement?

Except as otherwise provided below, qualifying Eligible Employment-Related Expenses must be incurred *during* the Plan Year and while you are covered under the DCSA Component. You may not be reimbursed for any Eligible Employment-Related Expense arising before the DCSA become effective, before your Election Form becomes effective, or for any such expenses incurred after the close of the Plan Year, or, after a separation from service or other loss of eligibility for the DCSA Component.

- You may not use DCSA amounts to reimburse any qualifying Eligible Medical Expenses and HCSA amounts may not be used to reimburse qualifying Eligible Employment-Related Expenses.

Q-37. What if the qualifying Eligible Employment-Related Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for DCSA reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual qualifying Eligible Employment-Related Expenses you have incurred, on the one hand, and the annual DCSA reimbursement amount you have elected and paid for, on the other. Any amount credited to a DCSA shall be forfeited by the Participant and restored to the Company if it has not been applied to provide reimbursement for qualifying Eligible Employment-Related Expenses that are incurred during the Plan Year (or its Grace Period, if applicable) and submitted for reimbursement by the end of the applicable Run-Out Period. This is the so-called “use-it-or-lose-it” rule under applicable tax laws. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable law and IRS and/or DOL guidance (in the Plan Administrator’s sole discretion).

Q-38. Will I be taxed on the DCSA Benefits I receive under the Plan?

You will not normally be taxed on your DCSA Benefits so long as your family aggregate DCSA reimbursement (under this DCSA and/or another employer’s DCSA) does not exceed the maximum annual reimbursement limits described above and other applicable requirements described above are satisfied. If you are reimbursed for a claim that is later determined to not be for qualifying Eligible Employment-Related Expenses, then you will be required to repay the amount. Alternatively, the Plan Administrator may offset the amount against any other qualifying Eligible Employment-Related Expenses

submitted for reimbursement or withhold the amount from your pay, as permitted by applicable law. The Plan Administrator or Company, however, cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. Ultimately, it is your responsibility to determine whether any reimbursement under your DCSA constitutes qualifying Eligible Employment-Related Expenses that qualify for income tax exclusion. If you have any questions about which expenses are or are not likely to be reimbursable from your DCSA, please contact the Third Party Administrator. However, please remember that the Third Party Administrator, the Plan Administrator and/or the Company may not provide any legal advice. If you need an answer upon which you may rely, you should consult with a tax professional.

Q-39. If I elect DCSA Benefits, will I still be able to claim the dependent care tax credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under the DCSA Component, although the balance of your qualifying Eligible Employment-Related Expenses may be eligible for the dependent care tax credit. For more information about the dependent care tax credit and how it works, see IRS Publication No. 503 (Child and Dependent Care Expenses). You may also wish to consult a tax professional for more information.

Q-40. What happens to unclaimed DCSA reimbursements?

Any DCSA reimbursement benefit payments that have been approved and remain unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year immediately following the Plan Year in which the Eligible Employment-Related Expense was incurred shall be forfeited. Any amounts so forfeited will be applied in a manner that is consistent with applicable law and IRS guidance (in the Plan Administrator's sole discretion).

Q-41. What happens if my claim for reimbursement under my DCSA is denied?

You will have the right to a full and fair review process. You must refer to Appendix I for a detailed summary of the Plan's claims procedures that must be followed in order to make a claim for DCSA Benefits and to appeal any denied claim.

Q-42. How long will the DCSA Component remain in effect?

Although the Employer expects to maintain the DCSA Component indefinitely, it has the right to modify or terminate the Plan or any of its components, such as the DCSA Component, at any time for any reason.

Q-43. What are HSA Benefits?

As described earlier, the HSA Component permits eligible employees to make pre-tax contributions to HSAs that they establish and maintain outside the Plan with an HSA trustee/custodian. For purposes of the Cafeteria 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 an Election Form with the Company. Because the share of the contributions that you make will be with pre-tax funds, you may save federal income, state income (in most instances) and Social Security taxes.

To participate in the HSA Component, you must be an HSA-Eligible Individual. This means that you are eligible to contribute to an HSA under the requirements of Code Section 223 and that you have elected

qualifying HDHP coverage offered by the Employer and do not have any other disqualifying non-HDHP coverage. If you elect HSA Benefits, you will be required to certify that you are an HSA-Eligible Individual and meet all of the requirements under Code Section 223 to be eligible to contribute to an HSA. As noted above, these requirements include such things as not having any disqualifying coverage, such as coverage under the Health Care FSA option under this Plan. You should also 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. If you elect HCSA Benefits, you cannot also elect HSA Benefits (or otherwise make contributions to an HSA) unless you elect the Limited Purpose FSA option. (Also, see Q-27 regarding the impact of the HCSA Component's carryover provision on HSA eligibility.)

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

Q-44 What is my HSA?

An HSA is not a Company-sponsored employee benefit plan - it is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code Section 223. Consequently, an HSA trustee/custodian, not the Company, will establish and maintain your HSA. Your HSA is administered by the HSA trustee/custodian. The Company's role is limited to allowing you to contribute to your HSA on a pre-tax payroll deduction basis. The Company or Plan Administrator has no authority or control over the funds that have been deposited in your HSA.

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

Q-45 What are the maximum HSA Benefits that I may elect under the Plan?

Your annual contribution for HSA Benefits is equal to the annual benefit amount that you elect. The amount you elect must not exceed the statutory maximum amount for HSA contributions applicable to your HDHP medical plan coverage option (that is, single or family) for the calendar year in which the contribution is made (for example, \$3,550 for single and \$7,100 for family are the statutory maximum amounts for 2020). Per applicable Code rules, an additional catch-up contribution of \$1,000 currently may be made if you are age 55 or older.

In addition, the maximum annual contribution shall be:

- (a) reduced by any Company contributions made on your behalf to your HSA (other than pre-tax payroll deductions) made under the Plan); and
- (b) prorated 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 of the requirements under Code Section 223 to be eligible to contribute to an HSA on December 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (that is, 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 Section 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 penalty (exceptions apply in the event of death or disability).

Q-46 How are my HSA Benefits paid for under the Plan?

When you complete the Election Form, you specify the amount of HSA Benefits that you wish to pay for with payroll deductions. After the effective date of your enrollment, each paycheck will be reduced by an amount equal to a pro-rata share of your annual contribution amount (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). Such contributions will be forwarded to the HSA trustee/custodian (or its designee) within a reasonable time after being withheld.

Q-47 Will I be taxed on the HSA Benefits that I receive under the Plan?

You may save federal income, state income (in most instances) and Social Security taxes by participating in the 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).

The Company or Plan Administrator cannot guarantee that specific tax consequences will follow from your participation in the Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA Benefits. Please remember that the Third Party Administrator, the Plan Administrator and/or the Company may not provide any legal advice. If you need an answer upon which you may rely, you should consult with a tax professional.

Q-48 Can I change my HSA contribution amount under the Plan?

You may increase, decrease or revoke your HSA contribution election on a prospective basis at any time during the Plan Year for any reason by submitting an Election Change Form to the Plan Administrator in accordance with its administrative procedures for processing election changes. For more information, see Appendix II - Election Changes. Your ability to make pre-tax contributions under this Plan toward HSA Benefits ends on the date that you cease to meet the HSA Component's eligibility requirements.

Q-49 Where can I get more information on my HSA and its related tax consequences?

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

Q-50 What are my ERISA rights?

The HCSA Component is a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Cafeteria Plan itself and the rest of its components (that is, the Premium Expense, DCSA and HSA Components) are not subject to ERISA. For information on your ERISA rights under the HCSA Component, please refer to the Wrap SPD.

Q-51 What else should I know about the Plan and its components?

The Plan is intended to qualify as a cafeteria plan under Code Section 125 and the regulations issued thereunder and, notwithstanding anything to the contrary in this Summary, will be interpreted by the Plan Administrator to accomplish that purpose.

The HCSA Component is intended to qualify as a self-insured medical reimbursement plan under Code Section 105, and the qualifying Eligible Medical Expenses reimbursed thereunder are intended to be eligible for exclusion from each applicable Participant's gross income under Code Section 105(b).

The DCSA Component is intended to qualify as a dependent care assistance program under Code Section 129, and the qualifying Eligible Employment-Related Expenses reimbursed thereunder are intended to be eligible for exclusion from each applicable Participant's gross income under Code Section 129(a).

The HCSA Component and DCSA Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Sections 105 and 129, respectively. The HCSA Component also is a separate plan for purposes of applicable provisions of ERISA, HIPAA and COBRA.

Many aspects of your HSA, if applicable (for example, with respect to investments or distributions) are not described in this Summary. You must consult the HSA trust or custodial documents provided by the applicable HSA trustee/custodian for any such information.

APPENDIX I – CLAIMS REVIEW PROCEDURE

The Plan Administrator has established the following claims review procedure in the event you are denied a benefit under this Cafeteria Plan. The procedure set forth below does not apply to any benefit claims filed under the Benefit Plan Options other than the HCSA and DCSA Components of the Cafeteria Plan. Such procedure also does not apply to claims relating in any way to the HSA established and maintained by you outside of the Plan with your HSA trustee/custodian, if any (e.g., issues involving the investment or distribution of any HSA funds). Any such HSA-related claims will be administered by your HSA trustee/custodian in accordance with the HSA trust or custodial agreement between you and such trustee/custodian.

After you timely submit your claim for reimbursement under the HCSA or DCSA Component in accordance with the Third Party Administrator's procedures (see Q-17 and Q-35), the Third Party Administrator will decide if the claim is eligible for reimbursement.

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

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

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

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

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

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

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

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the Plan Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

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

Important Information

Other important information regarding your appeals:

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

Claims Deadline

Unless otherwise required pursuant to applicable law, a claim for benefits under the Cafeteria Plan must be made within one year after the date the applicable expense was incurred that gives rise to the claim. You (or your designee, if applicable) are responsible for ensuring that this requirement is satisfied.

Limitations Period for Filing Suit

Unless otherwise required pursuant to applicable law, any suit for benefits under the Cafeteria Plan must be brought within one year after the date of a final decision on the related claim in accordance with the claims review procedures described above.

APPENDIX II – ELECTION CHANGES

Participants can change their elections under the Cafeteria Plan during a Plan Year if an event occurs that is a Status Event and certain other conditions are satisfied, as described below. For details, see the various Status Event headings below for the specific type of Status Event: Leaves of Absence, including FMLA Leaves; Changes in Status; Special Enrollment Rights; Certain Judgments, Decrees and Orders; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note, not all Status Events apply to all Plan benefits - the applicable exclusions are described under the relevant Status Event headings. Also, the Plan Administrator may change certain elections on its own initiative (see Q-6). Also, certain election changes that are permitted under this Plan may not be permitted under an underlying medical, dental or vision plan (e.g., the insurance carrier may not allow an election change). If an election change is not permitted under such plan, then no election change is permitted under the Cafeteria Plan. Likewise, an underlying medical, dental or vision plan may allow an election change that is not permitted by this Cafeteria Plan. In that case, your pre-tax pay reduction with respect to such plan may not be changed even though a coverage change is permitted under such plan.

If any Status Event occurs, you must inform the Plan Administrator and complete an Election Change Form within 30 calendar days after the occurrence of such event (or within 60 calendar days after the occurrence in the case of a special enrollment right due to loss of eligibility for Medicaid or state children's health insurance program ("SCHIP") coverage, or eligibility for a state premium assistance subsidy from a Medicaid plan or through SCHIP with respect to coverage under the Employer's medical plan option ("Medical Plan")). If the change involves a loss of your Spouse's or other Eligible Dependent's eligibility for Health Plan Coverage, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the applicable Status Event, even if you do not request it within the applicable time period(

1. **Leaves of Absence (Applies to Health Plan Coverage, HCSA Benefits and DCSA Benefits).** You may change an election under the Cafeteria Plan upon a FMLA or non-FMLA leave only as described in Q-8.
2. **Change in Status (Applies to Health Plan Coverage, HCSA Benefits (as limited below), and DCSA Benefits).** Election changes may be allowed if a Participant or the Participant's Spouse or other Eligible Dependent experiences one of the following Changes in Status. The election change must be on account of and correspond with the Change in Status, as determined by the Plan Administrator.
 - a change in your legal marital status (such as marriage, death of a Spouse, divorce or annulment);
 - a change in the number of your Eligible Dependents (such as the birth of a child, adoption or placement for adoption of an Eligible Dependent or death of an Eligible Dependent);
 - any of the following events that change the employment status of you or your Spouse or other Eligible Dependent and that affect benefits eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours or your Eligible Dependent (such as termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; incurring a reduction or increase in hours of employment;

or any similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

- an event that causes your Eligible Dependent to satisfy or cease to satisfy an eligibility requirements for a particular benefit (such as attaining a specific age);
- a change in your or your Spouse's or other Eligible Dependent's placed of residence; or
- any other event permitted under Code Section 125 or regulations or IRS guidance issued thereunder that the Plan Administrator, in its sole discretion and on a uniform basis, determines is permitted under applicable law and under the Cafeteria Plan.

With the exception of enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective (generally the first of the month following the date you make the new election but it may be earlier depending on the Employer's internal policies or procedures). As a general rule, a desired election change will be found to be consistent with a Change in Status if such event affects eligibility for coverage (note, for DCSA Benefits, the event also may affect eligibility of Eligible Employment-Related Expenses for the dependent care tax exclusion). A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Eligible Dependents who may benefit under the Plan.

In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility.* For health benefits (that is, Health Plan Coverage and HCSA Benefits), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving a divorce, annulment, the death of a Spouse or other Eligible Dependent, or an Eligible Dependent ceasing to satisfy the eligibility requirements for coverage, an election to cancel health benefits for any individual other than the Spouse involved in the divorce or annulment, the deceased Spouse or other Eligible Dependent, or the Eligible Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel health coverage for the affected Spouse or other Eligible Dependent. However, there are instances in which you may be able to increase your pre-tax contributions to pay for COBRA continuation coverage of a Dependent. Contact the Plan Administrator for more information.

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

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or other Eligible Dependent gain eligibility for coverage under another employer's cafeteria plan or benefit plan as a result of a change in marital status or a change in the Participant's, or the Participant's Spouse's other Eligible Dependent's employment status, an election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.
- *DCSA Benefits.* With respect to DCSA Benefits, an election change is permitted only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the DCSA Component; *or* (2) the election change is on account of and corresponds with a Change in Status that affects the eligibility of DCSA expenses for the available tax exclusion under Code Section 129.

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

3. **Special Enrollment Rights (Applies only to Medical Plan Coverage).** If a Participant, Participant's Spouse and/or other Eligible Dependent are entitled to special enrollment rights under a Medical Plan+, an election change to correspond with the special enrollment right is permitted. Thus, for example, if an otherwise eligible employee declined enrollment in the Employer's Medical Plan for the employee or the Employee's otherwise Eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA), the employee may be able to elect Medical Plan coverage under the Plan for the employee and his or her Eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible employee gains a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may also be able to enroll the employee, the Employee's Spouse, and the Employee's newly acquired Eligible Dependent, provided that a request for enrollment is made within the applicable Change of Election Period. An election change that corresponds with a special enrollment right must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 calendar days. Please refer to the Medical Plan's summary plan description for an explanation of any special enrollment rights.

If an otherwise eligible employee (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; (2) loses coverage under a SCHIP under Title XXI of the Social Security Act; or (3) becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the employee is entitled to special enrollment rights under the Medical Plan, and an election change to correspond with the special enrollment right is permitted. Thus, for example, if an otherwise eligible employee declined enrollment in Medical Plan coverage for the employee or the employee's otherwise Eligible Dependents because of medical coverage under Medicaid or SCHIP and eligibility

for such coverage is subsequently lost, the employee may be able to elect Medical Plan coverage for the employee and his or her Eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible employee and/or Eligible Dependent gains eligibility for group health plan premium assistance from SCHIP or Medicaid, the employee may also be able to enroll the employee, and the employee's Eligible Dependent, provided that a request for enrollment is made within the 60 calendar days from the date of the loss of other coverage or eligibility for premium assistance. Please refer to the Medical Plan's summary plan description for an explanation of any special enrollment rights.

4. **Certain Judgments, Decrees and Orders (Applies to Health Plan Coverage and HCSA Benefits, but not to DCSA Benefits).** If a judgment, decree or order from a divorce, separation, annulment or custody change requires an Eligible Dependent child to have Health Plan Coverage or be covered under the HCSA Component, an election change to provide coverage for such child is permissible. If the order requires that another individual (such as your former Spouse) cover the child, and such coverage is actually provided, you may change your election to revoke coverage for such child.
5. **Entitlement to Medicare or Medicaid (Applies to Health Plan Coverage and HCSA Benefits, but not to DCSA Benefits).** If a Participant or the Participant's Eligible Dependents become entitled to Medicare or Medicaid (i.e., becomes enrolled in), an election to cancel that person's health coverage is permitted. Similarly, if a Participant or Participant's Eligible Dependents who have been entitled to Medicare or Medicaid loses eligibility for such, you may elect to begin or increase that person's health coverage.
6. **Change in Cost (Applies to Health Plan Coverage and DCSA Benefits (as limited below), but not to HCSA Benefits).** If the cost charged to you for Health Plan Coverage or DCSA Benefits significantly increases during the Plan Year, you may choose either to make a corresponding increase in pre-tax contributions, revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or drop coverage altogether *if no other benefit package option provides similar coverage*. For this purpose, the HCSA is not similar coverage with respect to Health Plan Coverage, and coverage under another employer plan, such as the plan of an Eligible Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage. If the cost of Health Plan Coverage or DCSA Benefits significantly decreases during the Plan Year, a Participant who elected to participate in another benefit package option may revoke the election and elect to receive coverage provided under the benefit plan option that decreased in cost. In addition, otherwise eligible employees who elected not to participate in the Plan may elect to participate in the benefit package option that decreased in cost. For *insignificant* increases or decreases in the cost of benefits, however, pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a HCSA.)

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

The Plan Administrator generally will notify you of increases or decreases in the cost of Health Plan Coverage; you generally must timely notify the Plan Administrator of increases or decreases in the cost of DCSA Benefits.

The change in cost provision described above applies to DCSA Benefits only if the applicable cost change is imposed by a dependent care provider who is not the Participant's relative.

7. **Change in Coverage (Applies to Health Plan Coverage and DCSA Benefits, but not to HCSA Benefits).** You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If a Participant's Health Plan Coverage or DCSA Benefits coverage is significantly curtailed, the Participant may elect to revoke his or her election and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally - loss of one particular doctor in a network does not constitute significant curtailment.) If a Participant's Health Plan Coverage or DCSA Benefits coverage is significantly curtailed with a complete loss of coverage, the Participant may also drop coverage if no other similar coverage is available.
- *Addition or Significant Improvement of Plan Option.* If the Plan adds or significantly improves a benefit option during the Plan Year, a Participant may revoke his or her election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage.
- *Change in Election Under Another Employer Plan.* A Participant may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of the Participant's Eligible Dependent's employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the applicable IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan.
- *Loss of Other Group Health Coverage.* A Participant may change his or her election to add group health coverage under this Plan for the Participant or the Participant's Spouse or other Eligible Dependents if such individual(s) loses group health coverage sponsored by a governmental or educational institution (e.g., SCHIP).
- *DCSA Benefits.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant's dependent care service provider. For example, if the Participant terminates one dependent care service provider and hires a new one, then the Participant may change coverage to reflect the cost of the new provider, and if the Participant terminates a dependent care service provider because a relative becomes available to take care of the Qualifying Individual at no charge, then the Participant may cancel DCSA Benefits all together.

The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to the HCSA Component.)

8. **Change in HSA Elections.** If a Participant enrolled in the Plan during the Annual Election Period and elected HSA Benefits, then the Participant may increase, decrease or revoke his or her HSA Benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan Administrator's administrative procedures for processing election changes. No other benefit package option election changes can be made by the Participant as a result of the Participant's change in HSA Benefits election unless permitted as a result of another Status Event, as described above. For example, a Participant generally would not be able to terminate an HCSA Benefits election in order to be eligible for an HSA, unless one of the exceptions described above for HCSA Benefits otherwise applied.