

BAYLOR CAFETERIA PLAN
PLAN SUMMARY

TABLE OF CONTENTS

**I
ELIGIBILITY**

1. When can I become a participant in the Plan? 1
2. What are the eligibility requirements for our Plan? 1
3. When is my entry date?..... 1
4. What must I do to enroll in the Plan?..... 1

**II
OPERATION**

1. How does this Plan operate? 2

**III
CONTRIBUTIONS**

1. How much of my pay may the Employer redirect?..... 2
2. How much will the Employer contribute each year? 2
3. What happens to contributions made to the Plan?..... 2
4. When must I decide which accounts I want to use? 2
5. When is the election period for our Plan? 2
6. May I change my elections during the Plan Year?..... 2
7. What additional mid-year election changes are permitted in 2020 due to the COVID-19 pandemic? 3
8. May I make new elections in future Plan Years?..... 3

**IV
BENEFITS**

1. Health Flexible Spending Account 4
2. Dependent Care Flexible Spending Account 4
3. Premium Expense Account..... 5
4. May I direct Plan contributions to my Health Savings Account?..... 5

**V
BENEFIT PAYMENTS**

1. When will I receive payments from my accounts? 5
2. What happens if I don't spend all Plan contributions during the Plan Year? 5
3. Family and Medical Leave Act (FMLA) 6
4. Uniformed Services Employment and Reemployment Rights Act (USERRA) 6
5. What happens if I terminate employment?..... 6
6. May I continue coverage under the Health Flexible Spending Account after I terminate employment? 6
7. Will my Social Security benefits be affected? 6

**VI
HIGHLY COMPENSATED AND KEY EMPLOYEES**

1. Do limitations apply to highly compensated employees? 6

**VII
PLAN ACCOUNTING**

1. Periodic Statements..... 7

**VIII
GENERAL INFORMATION ABOUT OUR PLAN**

1. General Plan Information..... 7
2. Employer Information..... 7
3. Plan Administrator Information 7
4. Service of Legal Process 7
5. Type of Administration..... 7
6. Claims Submission 8

**IX
ADDITIONAL PLAN INFORMATION**

1. Claims Process 8
2. Qualified Medical Child Support Order..... 9

BAYLOR CAFETERIA PLAN

INTRODUCTION

We have amended the "Baylor Cafeteria Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Plan Summary ("Summary"). We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This Summary describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this Summary and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This Summary describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this Summary change, we will notify you.

Notwithstanding anything in the Plan or this Summary to the contrary, the Plan has been established and is maintained as a "church plan" within the meaning of Internal Revenue Code Section 414(e) and Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended that is exempt from Title I of ERISA and the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this Summary does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this Summary entitled "General Information About the Plan."

I ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

You can join the Plan on the same day you can enter our group medical plan.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for a portion of the benefits you have elected.

II OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. Also, we may make Employer contributions to your Health Savings Account if you participate in the Health Savings Account. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

III CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. How much will the Employer contribute each year?

We may contribute a discretionary amount which we will determine prior to the beginning of each Plan Year. This contribution can be used only for the Health Savings Account. If you elect not to participate in the Health Savings Account, the Employer will not contribute to the Plan on your behalf.

3. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) by the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

4. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

5. When is the election period for our Plan?

You will make your initial election within 31 days of your date of hire. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

6. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance or if you decide to participate in the Health Savings Account.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

You may revoke your coverage under the employer's group health plan outside of our open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke your coverage under our Employer sponsored group health plan if you are eligible to obtain coverage through the health exchanges.

If you are eligible to make a new election based on one of the events described above, you generally must make the new election within 31 days of the occurrence of the event (60 days for certain special enrollment rights). Any change will only apply prospectively, unless permitted to be made retroactively under law.

7. What additional mid-year election changes are permitted in 2020 due to the COVID-19 pandemic?

In addition to the above, if you have an election for benefits under the Health Flexible Spending Account in 2020, beginning as of June 23, 2020, you may change your election for any reason through the end of 2020. However, you may not reduce your election below the greater of (i) the amount you have already contributed for 2020 or (ii) the total reimbursements that have been charged to your account for 2020. Also, if you have an election for benefits under the Dependent Care Flexible Spending Account in 2020, beginning as of June 23, 2020, you may change your election for any reason through the end of 2020. However, you may not reduce your election below the amount you have already contributed for 2020.

8. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will assume you have elected not to participate in the Health Flexible Spending Account, the Dependent Care Flexible Spending Account, and the Health Savings Account for the upcoming Plan Year, but we will assume that your elections remain the same for all other benefits.

IV BENEFITS

1. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our medical plan and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

Drug costs, including insulin and "over the counter" drugs, may be reimbursed. You may also be reimbursed for expenses for menstrual care products. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

For 2020, the most you can contribute is \$2750. After 2020, the dollar limit may increase for cost of living adjustments.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses. The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the month in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

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

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

2. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- (a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- (b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- (c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service

provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

3. Premium Expense Account

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our self-funded medical plan.
- Dental insurance premiums.
- Cancer insurance premiums.
- Vision insurance premiums.
- Accidental death and dismemberment insurance premiums.

Under our Plan, we will establish sub-accounts for you for each different type of coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any contracts providing benefits described above. Also, your coverage will end when you leave employment, are no longer eligible under the terms of any coverage, or when coverage terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

4. May I direct Plan contributions to my Health Savings Account?

Yes. Any monies that you do not apply toward available benefits can be contributed to your Health Savings Account, which enables you to pay for expenses which are not covered by our medical plan and save taxes at the same time. Please see your Plan Administrator for further details.

V BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. The provisions of the insurance contracts will control what benefits will be paid and when. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

If you have not spent all the amounts in your Health Flexible Spending Account or Dependent Care Flexible Spending Account by the end of the Plan Year, you may continue to incur claims for expenses during the "Grace Period." The "Grace Period" extends 2 1/2 months after the end of the Plan Year, during which time you can continue to incur claims and use up all amounts remaining in your Health Flexible Spending Account or Dependent Care Flexible Spending Account.

Any monies left at the end of the Plan Year and the Grace Period will be forfeited, except for amounts contributed to your Health Savings Account. Obviously, qualifying expenses that you incur late in the Plan Year or during the Grace Period for which you seek reimbursement after the end of such Plan Year and Grace Period will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 30 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 30 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account

before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

- (a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- (b) You will still be able to request reimbursement for qualifying dependent care expenses incurred prior to your date of termination from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection and contributions will be made on your behalf after you terminate. You must submit claims within 30 days after termination.
- (c) Your participation in the Health Flexible Spending Account will cease, and no further salary redirection and contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. You must submit claims within 30 days after termination. Notwithstanding the foregoing, you may elect continuation coverage under the Health Flexible Spending Account as described in the next question.
- (d) Your Health Savings Account amounts will remain yours even after your termination of employment.

6. May I continue coverage under the Health Flexible Spending Account after I terminate employment?

If you terminate employment, you will be given the opportunity to continue participation in the Health Flexible Spending Account for the remainder of the Plan Year on a self-pay basis at the same coverage level that you had under the Health Flexible Spending Account on the day before your termination. If you elect continuation coverage, it will cease at the end of the Plan Year and cannot be continued for the next Plan Year. The Grace Period will not apply to continuation coverage. The continuation coverage will be subject to all conditions and limitations under the Employer's policy for continuation coverage.

7. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Baylor Cafeteria Plan is the name of the Plan.

The provisions of your amended Plan become effective on January 1, 2020. Your Plan was originally effective on September 1, 1994.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

Your Employer's name, address, and identification number are:

Baylor University
One Bear Place
Waco, Texas 76798
74-1159753

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Baylor University
One Bear Place
Waco, Texas 76798
800-229-5678

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Baylor University
One Bear Place
Waco, Texas 76798

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

WageWorks, Inc.
P.O. Box 14054
Lexington, KY 40512

**IX
ADDITIONAL PLAN INFORMATION**

1. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 30 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Health Flexible Spending Account claims within 30 days after your termination of employment. For the Dependent Care Flexible Spending Account, you must submit claims no later than 30 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Dependent Care Flexible Spending Account claims within 30 days after your termination of employment. Any claims submitted after that time will not be considered.

Claims that are insured or self-funded will be handled in accordance with procedures contained in the insurance policies or contracts. All other general requests should be directed to the Administrator of our Plan. If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial;
- (b) Reference to the specific Plan provisions on which the denial was based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures;
- (e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by an individual who is neither the individual who made the adverse determination nor a subordinate of that individual.

2. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.