COLBY SAWYER COLLEGE
FLEXIBLE BENEFIT PLAN
SUMMARY PLAN
DESCRIPTION

Effective:  
February 1, 1990

Amended & Restated:  
July 1, 2007
NOTICE TO EMPLOYEES PARTICIPATING IN THE FLEXIBLE BENEFIT PLAN

Following is a Summary Plan Description (SPD), which explains the Flexible Benefit Plan, and provides some final details. This notice summarizes administrative aspects of this Plan such as the frequency of adjustments on your paycheck, how to submit reimbursement claims and the claims payment process. Please read both this notice and the Summary Plan Description carefully.

PAY REDUCTION ADJUSTMENTS

Premium Conversion - Pay reduction adjustments for your employer-sponsored insurance premium contributions (if applicable) will be taken from your gross wages before tax rather than from your net wages after tax.

Health or Dependent Care Reimbursement Plan(s) - If you elected to participate in the Health or Dependent Care Reimbursement Plan accounts, the pay reductions you elected will be taken in equal installments from each paycheck throughout the Plan Year until the Plan maximum or the maximum you designated has been reached. Each time you receive a payroll check, an amount equal to the pay reduction will be added to your account.

SUBMITTING HEALTH OR DEPENDENT CARE CLAIMS

To obtain reimbursement from your Health Care and/or Dependent Care Reimbursement Plan accounts you must follow these steps:

1) Claim Form – Fill out the Request For Reimbursement form. These forms will be sent to you if you enroll in either Health or Dependent Care Reimbursement Plans. They are also available from your employer, or can be downloaded from the following website: www.benstrat.com. Submitted forms must be filled out completely including your signature. List the expenses you are requesting reimbursement for clearly showing the amount, the date the service was incurred, and a brief description of the service, then attach the third party documentation (see description below) to the claim form.

2) Third Party Documentation - Reimbursement can be made only for proven out-of-pocket expenses incurred during the Plan Year. (Regarding health expenses, they must be first submitted to your medical/dental/vision insurance plans where applicable.) You must provide third party documentation of all your health and/or dependent care expenses.
   Documentation must clearly show: * the date the expense was incurred (not the date paid), * the amount of the expense that you are responsible for, * the provider of services, and * a description of the service and/or expense.
   Eligible documentation includes statements, itemized bills, and insurance “Explanation of Benefits” forms. Make copies if necessary; documentation will not be returned to you.
   To help document dependent care expenses, a dependent care provider receipt is included on the Request For Reimbursement form. You may use other receipts as well.

3) Where to Submit Claims – Requests for Reimbursement and account inquiries should be directed to the Claims Service Provider and Account Administrator for the Employer by either mail or FAX at the following address:

   Benefit Strategies LLC
   PO BOX 1300
   Manchester, NH 03105-1300
   Telephone: (603) 647-4666  FAX: (603) 647-4668

4) Reimbursement - Claims received by 12:00 noon on Thursday are generally processed for reimbursement on Friday or by the following week at the latest. Health Care claims will be reimbursed up to the full amount of your election (reduced by previously paid claims) at all times during the Plan Year. Dependent Care claims will be reimbursed up to the balance in your account. The remaining amount will be held until sufficient funds have accumulated. Payments will not be made which exceed your account balance.
We are pleased to present you with this Summary Plan Description ("SPD"), which explains the Flexible Benefit Plan in easy to understand terms. It is intended only as an overview of the Plan provisions, and is less technical than the legal documents and insurance contracts that govern the Plan. We have made every effort to have this SPD accurately reflect the Plan document, however, if there is any conflict or inconsistency between this SPD and the Plan documents, the Plan documents (available for inspection in the office of the Employer) will govern. No provision of the Plan or this summary shall give any employee any right to continued employment, or prohibit changes in the terms or conditions of employment of any employee covered by the Plan.

INTRODUCTION
In the past you may have thought of the salary you are paid for the work you do and the benefit plans available to you as two separate programs. Actually, your salary and benefits together form your total compensation program.

With the Flexible Benefit Plan, you receive more choices in your benefit program and more flexibility in how to pay for those choices. The Plan allows you to elect certain optional nontaxable benefits as alternatives to cash compensation that would be taxable. As a result, your total compensation is delivered more tax effectively. Your contributions toward the cost of nontaxable benefits are not subject to federal income tax, state income tax (if applicable) or FICA/Medicare tax.

Your Flexible Benefit Plan has three parts:

1) Premium Conversion Plan: allows you to pay for your share of the cost of the Employer-sponsored insurance plans on a before-tax basis;

2) Health Care Reimbursement Plan: allows you to contribute pre-tax dollars into an account which can then be used to reimburse you for your family’s out-of-pocket medical/dental/vision expenses that are not reimbursed by insurance;

3) Dependent Care Reimbursement Plan: allows you to contribute pre-tax dollars into an account which can be used to reimburse you for the dependent day care expenses you incur which allow you and your spouse (if applicable) to be gainfully employed.

ELIGIBILITY REQUIREMENTS
Employees who earn compensation and who satisfy the Eligibility and Waiting Period requirements listed in Appendix A found at the end of this document are qualified to participate in the Flexible Benefit Plan.

(Owner-employees of the Employer (including partners, if applicable) are not eligible to participate. If the Employer is organized as a subchapter S corporation, 2% or greater shareholders are not eligible to participate.)

CONTRIBUTIONS
Money to fund the plan comes from salary reduction. Under the Flexible Benefit Plan you may choose to receive your full compensation in cash, or you may elect to have a portion of your pay set aside before any taxes have been deducted toward the payment of your share of insurance premiums or contributed to the Health or Dependent Care Reimbursement Accounts. The Maximum Salary Reduction allowable in the Plan Year is shown in Appendix A found at the end of this document.

Social Security or Retirement Plan Impact
It should be noted that because the amount of your salary reduction is not subject to FICA taxes, it is also not included in determining your average wages for Social Security benefit purposes. For example, if you reduce your salary in one year from $20,000 to $18,000 through the use of this Plan, the salary included in your Social Security wage history for that year would be $18,000 rather than $20,000. The exact effect this will have on your Social Security benefits is difficult to estimate since your benefits are based on your salary history throughout your working career, your marital status, and other factors, but your Social Security benefits may be reduced.

Participation will not affect the amount of benefits under any Employer sponsored retirement plans that may be provided to you. Your full compensation will be considered when determining your retirement benefits, without regard to your salary reduction.
PREMIUM CONVERSION

This part of the Flexible Benefit Plan allows you to use before-tax dollars to pay the employee share of the premiums for your Employer sponsored insurance plans. The Insurance Plans Eligible for Premium Conversion are listed in Appendix A found at the end of this document. If you decide to use the Premium Conversion option, your portion of insurance premiums will be deducted from your pay before federal, state and FICA taxes.

Your share of the cost will be determined each year by your Employer. If there is a change in your share of the cost during the Plan Year, the Employer may on a reasonable and consistent basis automatically make a prospective increase or decrease in your salary reduction.

HEALTH CARE REIMBURSEMENT PLAN

If you elect to participate in the Health Care Reimbursement Plan, your Employer will make the contributions you designate in an account on your behalf. This account will be used to reimburse you for eligible health care expenses for you and your eligible dependents that are not reimbursed by insurance.

Eligible Dependents

Eligible dependents are your spouse, qualifying children and other qualifying relatives for whom you provide more than half of their support.

Qualifying children include your natural, adopted, foster and step children, brother, sister, stepbrother or stepsister and any descendents of these who:

1) Live with you for more than half of the calendar year,
2) Are less than age 19 as of the end of the calendar year (less than age 24 if a full-time student) or are permanently and totally disabled, and
3) Do not provide over half of their own support.

Eligible Health Care Expenses

You may use your Health Care Reimbursement Account to be reimbursed for the "out-of-pocket" expenses you incur for medical care during the Plan Year (the Plan Year is shown in the General Information found at the end of this document). The expense must be INCURRED during the Plan Year to be eligible for reimbursement, not necessarily paid.

Allowable expenses for medical care includes:

- Medical and dental expenses which are covered but not paid by insurance (deductible amounts paid before benefits begin and the percentage of charges not covered, and/or co-payments)
- Vision and hearing expenses including examinations, eyeglasses, contact lenses and solutions, hearing aids and their batteries, and seeing-eye dogs. Laser or lasic eye surgery is also eligible.
- Fees paid to doctors, licensed therapists, chiropractors and hospitals
- Dental care including orthodontia payments
- Routine physical examinations, x-rays and lab fees
- Prescription drugs including insulin and birth control pills, and co-payments for prescription drugs
- Non-prescription over-the-counter (OTC) drugs taken for a medical condition if allowed by your Employer (as shown in Appendix A).
  Toiletries (e.g. toothpaste), cosmetics (e.g. face cream), and dietary supplements taken for general health reasons (e.g. vitamins, herbs) are NOT eligible.
- Special equipment bought or rented because of a physical problem (wheelchairs, crutches, orthopedic shoes, etc.)
- Ambulance service necessary to receive medical care
- Other expenses which would otherwise qualify as legitimate medical care deductions for federal income tax purposes excluding premiums you pay for health insurance
Ineligible expenses include:

- Medical expenses that are reimbursed by insurance;
- Cosmetic surgery and procedures
- Vitamins taken for general health
- Herbs, minerals and food supplements
- Insurance premiums including those paid by your spouse through his/her employer
- Expenses and insurance premiums for long term care.
- Expenses for which you are reimbursed through this plan may not be claimed as deductions for income tax purposes.

Health Care Reimbursement Limits
The amount available for reimbursement is limited to the amount that you designated as your contribution for the Plan Year. It is NOT limited to the contributions that have been made to your account at the time of reimbursement. The Maximum Reimbursement is shown in Appendix A found at the end of this document.

You may submit requests for reimbursement at any time during the Plan Year and up to 90 days following the end of the Plan Year for expenses incurred during the Plan Year.

Termination of Employment, Leave of Absence and COBRA Continuation
If your employment terminates, or you take an unpaid leave of absence, eligible expenses incurred prior to your separation will be reimbursed up to the amount remaining of your annual election. Eligible expenses incurred after your separation will be reimbursed only if you elect to continue contributions and benefits. Your rights to legally mandated continuation coverage are described in the COBRA Continuation Notice found at the end of this document. If you elect to continue benefits you must make the required payments in a timely manner.

Health Care Reimbursement Plan Continuation Coverage is available only if the amount of required payments for the remainder of the Plan Year does not exceed the maximum amount available to the Participant or Qualified Beneficiary for reimbursement for the Plan Year.

If you take an unpaid leave of absence under the provisions of the Family and Medical Leave Act (“FMLA”), and do not return to employment following the end of your leave, your coverage will terminate at the end of the FMLA leave. At that time, you may have the right to continue benefits as described in the attached COBRA Continuation Notice. If your leave of absence is due to a period of duty in the Uniformed Services of the United States and lasts more than 31 days, you may also continue this coverage.

Privacy of Health Information
In the administration of the Health Care Reimbursement Plan, the Plan Administrator and their designated Claims Service Provider may come in contact with your personal health information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) your Health Information is protected. The Plan Administrator and their claims service provider will not use or disclose your Protected Health Information for any reason other than that required for the operation of the Plan without your authorization. Please consult the Notice of Privacy Practices at the end of this document for additional information.

DEPENDENT CARE REIMBURSEMENT PLAN
If you elect to participate in the Dependent Care Reimbursement Plan, your Employer will make the contributions you designate to a bookkeeping account on your behalf. Expenses for dependent care that are considered employment related expenses are eligible for reimbursement from your account.

Eligible Dependent Care Expenses
Eligible dependent care expenses are expenses you incur for the care of your eligible dependents that enable you (and your spouse, if you are married) to be gainfully employed. If you are married, your spouse must be gainfully employed, a full-time student, or incapable of self-care.

Eligible dependents are:

- Your dependent children and other dependent relatives under the age of 13; or
- Your spouse; or
- Other dependent relative who is physically or mentally incapable of self-care who lives with you for more than one-half of the calendar year and, in the case of a dependent relative, who does not have income in excess of the exemption amount.

*(If you have any questions regarding who is an eligible dependent please contact your tax advisor, attorney etc.)
Your eligible dependents may receive care from a baby-sitter, dependent care center or someone who comes to your home. However, expenses for care of a dependent outside the home are eligible only if the qualifying dependent normally spends at least 8 hours per day in your household. If you utilize a care provider which cares for more than six non-resident persons, the care provider must be licensed and comply with all applicable state and local laws.

The types of expenses that are not reimbursable include care that is primarily educational or medical in nature, education at the kindergarten level or higher, and the cost of transportation to and from the care facility and any portion of the cost for overnight camp. Household services and expenses for food, clothing or entertainment (unless they are incidental to care) are not eligible. Also, services provided by your child under age 19 (or someone you can claim as a dependent on your tax return) are not reimbursable.

**Dependent Care Reimbursement Limits**

The maximum reimbursement you can get from the Dependent Care Reimbursement Plan is $5,000 per year or $2,500 per year if you are married filing separately. This will be paid to you on a pre-tax basis (not subject to federal, state (if applicable) or FICA tax). However, the tax benefit from these reimbursements is subject to limitations. You will be required to declare on your income tax return the amount of reimbursement, if any, that exceeds certain limits that are imposed by the tax laws. For example, the maximum reimbursement in a calendar year is $5,000, or $2,500 if you are married and file a separate return. In addition, your reimbursement may not be more than whichever of the following limitations apply:

- If you are single, your earned income (after salary reduction) for the year the expenses were incurred; or
- If you are married and your spouse is working, your earned income (after salary reduction), or the earned income of your spouse, whichever is less, for the year the expenses are incurred.

For purposes of applying the earned income limit, earned income generally means income from employment (such as wages, salaries, tips, etc.). If you are married and your spouse is either a full-time student or is physically or mentally incapable of caring for himself or herself you may assume an earned income of $250 in any one month if you have only one qualified dependent, or $416.67 in any one month if you have more than one qualified dependent.

**Termination of Employment**

If your employment terminates or you take an unpaid leave of absence, you may submit requests for reimbursement of dependent care expenses incurred during the Plan Year up to 90 days following the close of the Plan Year provided that the dependent care expenses were incurred before the last day of the Plan Year. Eligible dependent care expenses incurred after your separation but before the end of the Plan Year will be reimbursed up to the amount remaining in your account.

**Dependent Care Tax Credit**

In general, the Dependent Care Tax Credit allows you to reduce the amount of federal income taxes you owe by giving you a credit against your tax liability. The amount of the credit is a percent of eligible dependent care expenses. The percentage varies from 20% to 35% depending on your adjusted gross income. The amount of eligible expense toward which the credit can be applied is limited to the lesser of: 1) $3,000 for one child ($6,000 for two or more children); or 2) the earned income of the lower earning spouse.

You cannot claim Federal Dependent Care Tax Credit on your income tax return for dependent care expenses reimbursed from your Dependent Care Reimbursement Plan. Also, amounts reimbursed through your Dependent Care Reimbursement Plan will reduce, dollar for dollar, the maximum expenses available for determining the tax credit.

In certain cases, it may be more advantageous for you to claim a tax credit for your dependent care expenses rather than pay for those expenses through the Dependent Care Reimbursement Plan. Please, carefully consider both options and your own personal circumstances before choosing which one would be the most beneficial for your family. You may also want to consult a tax advisor.

Finally, you should be aware that you will be required to report the name, address, and tax identification number or social security number of your dependent care providers on your tax return if you use either the tax credit or the Dependent Care Reimbursement Plan.
ENROLLMENT AND ADMINISTRATION

ELECTION PROCESS
Each year you will have the opportunity to re-enroll or waive participation in the Flexible Benefit Plan. Please see Appendix A for the Premium Conversion Election Process. Health or Dependent Care Reimbursement Plan elections must be in writing on the form provided and received prior to the first day of the period of coverage. If you are a new employee, you may file an election after satisfying the waiting period (see Appendix A). If you have been on an FMLA leave or absent due to a period in the Uniformed Services, that leave time will count toward your satisfaction of the service requirement. New employees must make elections within 30 days of the satisfaction of the waiting period.

ELECTION CHANGES
Once an election becomes effective, it stays in effect until the following Plan Year. You may not change your election during the Plan Year except under the following circumstances.

1) If you have a change in status, you may be allowed to revoke your election and submit a new election for the remainder of the plan year, which is consistent with that change for the remainder of the Plan Year.

A change in status means any of the following:
- Changes in your legal marital status (i.e., marriage, divorce, death of a spouse, legal separation or annulment),
- Changes in the number of your dependent children (i.e., birth or death of a dependent, adoption or placement for adoption),
- Termination or commencement of employment of you, your spouse or a dependent,
- Changes in your work schedule or the schedule of your spouse or a dependent, including, changing from full-time to part-time (or vice versa), a strike, lockout or commencement or return from unpaid leave,
- Changes in employment status of a covered individual that affects eligibility under an employer plan
- Events which cause a dependent to satisfy or fail to satisfy the eligibility requirements of a plan, such as the dependent reaching the limiting age for coverage under a plan, or changes in the student status of the dependent, or
- Changes in your residence or work site for you, your spouse, or dependent.

You may revoke your election for the balance of a Plan Year and file a new election only if both the revocation and the new election are due to and consistent with the reason that such change was permitted, or if you, your spouse or dependent becomes eligible for continuation coverage under your Employer-sponsored health plan. A new election must be filed within thirty (30) days after the date of the change in status and will be effective on the first day of the payroll period following receipt of the election form.

For purposes of election changes for an accident and health plan, consistency means that the following conditions have been met:

a) The change in status results in an increase or decrease in the number of your dependents who benefit from coverage under this Plan, or an accident or health plan of your spouse or dependent’s employer, and
b) The election change corresponds with that gain or loss of coverage, and
c) If coverage under this Plan is terminated due to you or your dependent(s) becoming eligible under another employer’s accident or health plan, you must certify that you and/or covered dependents will obtain coverage under the other employer’s plan.

Change in status for any benefit offered under the Flexible Benefit Plan also includes other events as may be permitted under regulations and rulings of the Internal Revenue Service.

2) You may revoke an election under a group health plan and make a new election on a prospective basis that corresponds with the special enrollment rights provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the enrollment of both new and pre-existing dependents.
3) If you take an FMLA Leave, you may revoke an election for group health coverage and make another election for the remaining portion of the period of coverage as may be provided for under the Family and Medical Leave Act.

4) If there is a change in the cost or coverage of a benefit (excluding the Health Care Reimbursement Plan), you may revoke your election with respect to that benefit and make a new election for the remainder of the Plan Year.

Cost changes – Automatic election change: If the cost of a benefit you are purchasing with Premium Conversion increases (or decreases) during the plan year and you are required to make a corresponding change in your election, the Employer may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in your elections.

If the cost of a benefit you are purchasing with Premium Conversion significantly increases or decreases during the plan year, you may make a corresponding prospective election change. You may commence participation in an option that decreases in cost, and if another option that provides similar coverage is available under the plan, elect to receive coverage under that option. Cost increase or decrease for this purpose means a change in the amount of the elective contributions required under this plan, and may result from actions taken by you or the Employer.

With respect to the Dependent Care Reimbursement Plan only, a dependent care provider who is not your relative may impose a change in cost that permits you to make a new election. In addition, if your dependent care costs change due to an increase or decrease of hours, you may make a corresponding change to your dependent care election.

If the coverage under a benefit option ceases or is significantly curtailed, you may revoke your election and receive coverage under another benefit option with similar coverage on a prospective basis. If there is a loss of coverage, you may drop coverage if no other similar benefit option is available under the plan. A significant curtailment with a resulting loss of coverage includes: HMO not available in geographic area of residence; plan lifetime or annual cap has been reached; a substantial decrease in medical care providers in a PPO network or HMO; a hospital drops out of the plan or network; there is a reduction in benefits for a certain illness or injury for which a participant or family member is currently in a course of treatment; an increase in deductible, co-pay, out-of-pocket cost-sharing limit or any other similar fundamental loss of coverage.

If a new benefit option is added to the plan, or if coverage under an existing option is significantly improved during the plan year, you may revoke your election and elect coverage under the new or improved benefit option on a prospective basis.

If your spouse and/or your dependents are allowed to make an election change under another employer plan, you may make a corresponding election change. An election change is also permitted if a spouse or dependent participates in another employer plan that operates on a different plan year.

5) You may change your election for an accident or health plan if you are required to provide coverage for a child due to a court order or decree resulting from a divorce, legal separation, annulment, or change in legal custody. You may also cancel or terminate coverage for the child under these portions of the Plan if the court order or decree requires your former spouse or another person to provide coverage for the child, but only if your or your former spouse or another person subject to the order certifies that such coverage is in fact provided.

6) If you, your spouse, or a dependent enrolled in an employer-sponsored medical plan or a health care reimbursement plan becomes enrolled to receive Medicare or Medicaid benefits (other than coverage limited to benefits for distribution of pediatric vaccines), you may make a corresponding election change to cancel coverage for yourself, your spouse or the dependent, as applicable.

UNPAID LEAVES OF ABSENCE
If you take an unpaid leave of absence (including a Family and Medical Leave Act of 1993 "FMLA" or USERRA Leave), at your option you may continue any or all of your benefits under the Plan as long as you make the required contributions. You have the option of making contributions in any of three ways:

1) PRE-PAY: You can pay amounts that will become due during your leave on a pre-tax basis out of one or more paychecks preceding the beginning of the leave; or
2) PAY AS YOU GO: You can make pre-tax payments during your leave out of any payments you receive during your leave such as vacation pay, sick pay or wage continuation. If you are not receiving payments during your leave, or if the payments end during the leave, you can make payments directly to the Employer on an after-tax basis. You must make any after-tax payments to the Employer on or before each pay period (when contributions would have been taken) during the unpaid portion of your leave, all delinquent payments must be made within 30 days of their due date; or

3) PAY ON RETURN: You can pay amounts, which became due during the leave from one or more paychecks following your return to active employment, if you inform the Employer of this intention before the leave begins.

Payments made under options 1) or 3) will be made on a pre-tax (that is, salary reduction) basis. All salary reduction contributions must be made within the same Plan Year in which the leave began.

The Employer may enforce the catch-up Pay On Return option if you fail to make agreed upon pay-as-you go payments, regardless of whether or not an agreement was made in advance of the leave, to the extent permitted by state law.

If your participation in the Plan terminates during an unpaid leave of absence and you return from leave during the same Plan Year, your election for that Plan Year will be automatically reinstated on the same terms and conditions in effect prior to the unpaid leave of absence unless you revoke it in accordance with election change rules described above. However, you will have no greater right to benefits for the remainder of the Plan Year than a Participant who has not taken an unpaid leave of absence.

These same options apply if your leave of absence is due to a period of duty in the Uniformed Services of the United States and that duty lasts more than 31 days.

TERMINATION
Your participation in the Plan will cease upon termination of your employment or if you no longer meet the eligibility requirements.

The Flexible Benefit Plan has been designed to comply with all current laws regarding flexible benefit plans. Your Employer expects and intends to maintain the plan indefinitely, but it may be changed, amended, or terminated at any time. If the plan is terminated, you will not lose your right to benefits accrued prior to plan termination.

This Summary Plan Description merely summarizes the benefits provided pursuant to the Plan, and is not the legally controlling document. All determinations regarding benefit entitlement and Plan provisions are based upon the actual Plan documents, which are available for inspection at the office of the Plan Administrator.

**HEALTH AND DEPENDENT CARE REIMBURSEMENT ACCOUNTS**

The portion of your salary reduction that is designated for reimbursement of health care expenses or dependent care expenses goes into a Health or Dependent Care Account each time the reduction is taken from your paycheck. Accounts for Health and Dependent Care are separate. Funds cannot be transferred from one to the other. The account(s) will be decreased as reimbursement payments are made. The account(s) are for bookkeeping purposes only; no money is actually held in the account(s).

You may submit claims that were incurred during a Plan Year for up to 90 days (run-out period) after the end of that Plan Year, or if your Employer has approved an Extension Period following the end of the Plan Year (see Appendix A) you may be given up to an additional 2 ½ months following the end of the Plan Year to incur and be reimbursed for additional Qualified Expenses. Any remaining balance in your Account(s) after the time periods described above cannot be paid to you, combined, carried forward into the next Plan Year, or converted to cash and will be forfeited. You should, therefore, carefully anticipate your needs for the year before determining the amount of your election. Funds forfeited from the account(s) will be used by the Employer to offset the reasonable administrative expenses of the Flexible Benefit Plan.
REQUESTING REIMBURSEMENT FROM YOUR ACCOUNT(S)

In order to be reimbursed, eligible expenses must have been incurred during the Plan Year while you are a participant in the Health or Dependent Care Reimbursement Plan(s). Expenses are considered incurred on the date the services were provided. You may not receive advance reimbursement for future or projected expenses. For reimbursement of health care expenses, first submit the expenses to your insurance company to obtain whatever reimbursement is available from that source.

Health Care Reimbursement Plan claims will be reimbursed up to the full amount of your election (reduced by previously paid claims) at all times during the Plan Year. Dependent Care Reimbursement Plan claims will be reimbursed up to the balance in your Account at the time reimbursement is requested.

Submit eligible expenses for Health or Dependent Care reimbursement from your account as follows:

- A claim form and documentation must be submitted to the account administrator showing the amount of the expense, the date of service (must be within the Plan Year), the nature of the expense, and the name of the provider. You must include bills, invoices, detailed receipts or other statements verifying expenses. In addition, you will not seek reimbursement under any other plan. To be reimbursed for health care expenses, if the expense is covered by medical insurance, you must first submit the expenses to your insurance company to obtain whatever reimbursement is available from that source.

- The Claims Administrator will make a determination on claims submitted for reimbursement within 30 days of receipt unless a determination cannot be made due to reasons beyond the control of the Claims Administrator. In this case, a 15-day extension is available if you are notified of the extension within the initial 30-day period. If a determination on a claim cannot be made because you did not provide sufficient information, you have 45 days from receipt of a request to provide the required information.

- Request for reimbursement may be submitted until 90 days following the close of the Plan Year in which the expenses are incurred.

- You will be reimbursed directly. Payment will not be made to providers. Your Employer does not guarantee that the amounts reimbursed through these accounts will be excludable from gross income for federal or state income tax purposes. It is your responsibility to determine whether or not each payment you receive is a qualified excludable expense. You may wish to consult a tax advisor for assistance.

Reimbursements Using the *FlexExpress*® Electronic Payment Card

If a *FlexExpress*® Electronic Payment Card is offered in accordance with your plan (please see Appendix A) and you choose to obtain one, you may use this special MasterCard® to obtain reimbursement for eligible medical or dependent day care expenses at approved dependent day care or medical care providers including physicians, pharmacies, dentists, optometrists and hospitals.

Automatic reimbursement will occur when you use the Card at a provider that has been assigned a qualifying Merchant Category Code and the amount of the expense is less than or equal to your Health or Dependent Care Reimbursement Account balance.

To obtain a *FlexExpress*® Card, you must certify that the Card will be used ONLY for eligible health or dependent day care expenses incurred by yourself (the Cardholder) or by your eligible dependents during the Plan Year and that these expenses have not and will not be reimbursed under any other plan covering health benefits. When you sign your card, you are also certifying that you will abide by the Cardholder Agreement that is included with your Card. Each time the card is used, you are re-affirming this certification. Make sure you read your Cardholder Agreement carefully. In general the agreement includes the following provisions:

i. You are responsible for all charges incurred by using the Card. You can use the Card for payment only of eligible expenses as defined in the Plan Document(s) and under federal tax law. Eligible expenses must be incurred during the Plan Year. Do not use your Card to pay for services that were incurred outside of the Plan Year. Do not use your Card to pay for ineligible products or services.

ii. You affirm that you have not been reimbursed and will not seek reimbursement for these expenses under any other plan covering health benefits.
iii. If you use the Card for ineligible expenses as determined by the Plan Administrator/Claim Service Provider or IRS, you will have violated the Cardholder Agreement and your obligations under your Employer’s Plan. Upon notification, you must immediately re-pay the expense to the Plan. Your Card may be suspended or revoked for failure to comply, and funds may be withheld from your compensation to the extent allowed by law.

iv. You must retain proper documentation of all expenses the Card is used to pay for. You must submit this documentation to the Claims Service Provider upon request to verify that a payment was for an eligible expense incurred during the Plan Year. If documentation is not submitted within a reasonable period of time, the expense will be deemed ineligible and you will be required to re-pay the expense to the Plan.

v. If your Card is lost or stolen or if someone has used your Card without your permission, you will notify your Plan Administrator or Claims Service Provider.

CLAIM DENIAL
If you (or your dependent, if any) disagree with the determination of your benefit, you may file a written appeal with the Claims Administrator. The Claims Administrator is responsible for evaluating all benefit claims under the Plan. Accordingly, to obtain benefits, you must complete, sign, and submit to the Claims Administrator a written claim on the Administrator’s claim form, available from the Claims Administrator. Failure to utilize or complete the following claims procedures will result in your being barred from asserting the claim in any legal proceeding. Within 30 days after you file your appeal, the Claims Administrator will notify you whether your claim has been upheld or denied. This period may be extended on time for up to 15 days if the Claims Administrator determines that such an extension is necessary and provides an extension notice during the initial 30-day period. If an extension is necessary, a decision shall be made within 45 days after you file your claim. If you fail to provide sufficient information to determine whether benefits are covered or payable under the Plan, the Claims Administrator will notify you within 30 days after receipt of the claim and you will have at least 45 days to complete the claim.

If the Claims Administrator denies the claim, you will be provided with written or electronic notification of the following;

- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary.
- The specific reasons for the denial
- The specific reference to the Plan provisions on which the denial is based; and,
- An explanation of the claims review procedure for appeal of the denial.

Within 180 days after you receive notice that your claim has been denied, you or your representative may file a written request to the Claims Administrator to have the Claim Administrator’s denial reviewed by a new decision-maker, the Plan Administrator, who is not a subordinate of the initial decision maker. Failure to appeal within 180-day period will be deemed to be a failure to exhaust all administrative remedies under the Plan.

You or your representative may also submit comments, documents, records, and other information after the filing of the appeal that will be considered even if this information was not submitted or considered during the initial decision. You or your representative will be entitled to review a copy of the Plan and any other pertinent documents in the possession of the Employer upon request and free of charge. The Plan Administrator will render a decision upon review of a claim and communicate such decision to you within 45 days of the request.

If the Plan Administrator denies your appeal, you shall be provided with the following information:

- The specific reasons for the denial
- The specific references to the Plan provisions on which the denial is based; and,
- A statement describing your right to file suit pursuant to ERISA Section 502(a);
- A statement that you are entitled upon request to receive, free of charge, all documents and records relating to your denial; and
- A statement that “You and your Plan may have voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

Notwithstanding any statutory limitations period or conflict of law provision to the contrary, no action with respect to any benefit under this Plan may be brought more than six months following the date on which the notice of the adverse benefit determination on review is sent to you.
STATEMENT OF RIGHTS OF PLAN PARTICIPANTS

As a participant in the Health Care Reimbursement Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

1) Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator’s office and at the other specified locations, such as worksite and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if any and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

2) Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Health Care Reimbursement Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under this plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, if any, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay for costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
COBRA CONTINUATION NOTICE

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Health Care Reimbursement Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this Notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Health Care Reimbursement Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your Health Care Reimbursement Plan coverage because either one of the following qualifying events:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your Health Care Reimbursement Plan coverage because of any of the following qualifying events:

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Health Care Reimbursement Plan because any of the following qualifying events happen:

1. The parent-employee dies;
2. The parent-employee’s hours of employment are reduced;
3. The parent-employee’s employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Health Care Reimbursement Plan as a “dependent child.”

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is at the end of employment or reduction in hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events. The qualified beneficiary has 60 days from the termination date, or date of letter, whichever is later, to make their election once an election is made, the qualified beneficiary has 45 days to make payment.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator at the address listed in the General Information page of this Summary Plan Description.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Health Care Reimbursement Plan coverage would otherwise have been lost.

The monthly cost for continuation coverage may not exceed one-twelfth of your election to the Health Care Reimbursement Plan plus a two percent administrative surcharge. For example, if you elected $600, your monthly continuation cost would be $51.00 [(600/12) x 1.02]. The Plan Administrator will provide you with the appropriate cost information if you become eligible for continuation coverage.
COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end or employment or reduction of the employee’s hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Health Care Reimbursement Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration’s determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice must be in writing and should be sent to the Plan Administrator at the address listed on the General Information page of this Summary Plan Description.

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Health Care Reimbursement Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be in writing and sent to the Plan Administrator at the address listed on the General Information page of this Summary Plan Description.

**If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**Keep Your Plan Informed of Address Changes**

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

You may also have rights under state law to continuation coverage under medical, dental and group term life insurance plans offered by the Employer, if any. Please see the medical, dental and group term life insurance plan Summary Plan Description(s) for more detailed information.

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**NOTICE OF PRIVACY PRACTICES**

This Notice describes how medical information may be used or disclosed, and how you can get access to this information. This Notice applies to the Health Care Reimbursement Plan and does not apply to any other benefits provided under the Flexible Benefit Plan. The Plan is required to maintain the privacy of your protected health information (PHI) and to provide you with this Notice about its legal duties and privacy practices. The Plan Sponsor, Plan Administrator and third party providers understand the sensitivity of privacy issues and recognize that protecting the privacy and security of your PHI is an important responsibility.

Protected Health Information ("PHI") includes a combination of:

- Medical information about you and
- Individually identifiable information such as your name, address, phone number and social security number (or other identification number).

The Plan Administrator will follow the privacy practices described in this Notice, although the Plan Administrator and Plan Sponsor reserve the right to change the privacy practices and the terms of this Notice. If the practices or terms are changed, a new Notice will be provided to Health Care Reimbursement Plan participants prior to making a
significant change. These changes apply to all information, including PHI created or received before the Notice is changed.

**PHI Safeguards**
The Plan Administrator is committed to maintaining the security and confidentiality of information received from you relating to the Health Care Reimbursement Plan. Physical, electronic, and procedural safeguards will be maintained that comply with Federal and State laws to protect information against unauthorized access and use.

The Plan’s Privacy Officer has the overall responsibility of implementing and enforcing policies and procedures to safeguard your PHI against inappropriate access, use, and disclosure. Information on the Privacy Officer is contained on the General Information page of this Summary Plan Description.

**Permitted Uses and Disclosures of PHI**
PHI can be used or disclosed in a number of different ways. The following are only a few of the types of uses and disclosures of your PHI that are permitted by law to be made without your authorization:

**Treatment** – PHI may be disclosed to health care providers (e.g., doctors, dentists, pharmacies, hospitals, etc.) who request it in connection with your treatment. PHI may also be disclosed to health care providers in connection with preventative health, early detection and disease and case management programs.

**Payment** – PHI will be used and disclosed to administer your Health Care Reimbursement Plan which may involve determination of:
- Eligibility
- Reimbursement
- Utilization review and management
- Medical necessity review
- Coordination of care benefits and other services, and
- Responding to complaints, appeals and external review requests.

PHI may also be used and disclosed for purposes of obtaining premiums, underwriting, rate-making and determining cost sharing amounts.

**Health Care Operations** – PHI may be used and disclosed to perform the Health Care Reimbursement Plan’s functions as a health plan. This may include:
- Health improvement or health care cost reduction through population-based programs
- Competence and qualification review of healthcare professionals
- Fraud and abuse detection, and compliance programs
- Quality assessment and improvement activities assessment, health claims analysis, and health services outreach
- Case management, disease management, and care coordination services.

PHI may also be disclosed to affiliates and third party “business associates” that perform payment or health care operations activities for the Health Care Reimbursement Plan on your behalf.

In addition, the law permits use or disclosure of your PHI in the following situations without your authorization:

**Required by Law** – PHI may be used or disclosed to the extent that is required by State or Federal law.

**Public Health** – PHI may be disclosed to an authorized public health authority for purposes of public health activities. The information may be disclosed for such reasons as disease, injury or disability.

**Abuse or Neglect** – PHI may be disclosed to government authorities concerning abuse, neglect or domestic violence.

**Health Oversight** – PHI may be disclosed to a government agency authorized to oversee the healthcare system or government programs, including audits, examinations, investigations, inspections and licensure activity.

**Legal Proceedings** – PHI may be disclosed in the course of any legal proceeding, in response to an order of a court or administrative judge and, in certain cases, in response to a subpoena, discovery request or other lawful process.
Law Enforcement – PHI may be disclosed under limited circumstances to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crimes.

Coroners and Medical Examiners – PHI may be disclosed in certain instances to coroners and medical examiners.

Research – PHI may be disclosed to researchers, provided that certain established measures are taken to protect your privacy.

Threat to Health or Safety – PHI may be disclosed to the extent necessary to avert a serious or immediate threat to your health or safety or to the health or safety of others.

Military Activity and National Security – PHI may be disclosed to Armed Forces personnel under certain circumstances and to authorized federal officials for the conduct of national security and intelligence activities.

Correctional Institutions – If you are an inmate in a correctional facility, PHI may be disclosed to the correctional facility for certain purposes, including provision of health care to you or the health and safety of you or others.

Workers’ Compensation – PHI may be disclosed to the extent required by workers’ compensation laws.

Any uses and disclosures not described in this Notice will require your written authorization. If you provide an authorization, you may cancel it in writing at any time.

Your Rights Concerning Your PHI
You have additional rights with respect to your PHI:

Right to Request Restrictions – You have the right to ask that restrictions be placed on the use or disclosure of your PHI. However, the law does not require that the Plan agree to these restrictions. If the Plan Administrator does agree to a restriction, the Plan may not use or disclose your PHI in violation of that restriction unless it is needed for an emergency.

Confidential Communication – The Plan Administrator will accommodate reasonable requests to communicate with you about your PHI to an alternative location.

Access to PHI – You have the right to receive a copy of PHI about you that is contained in the “designated record set,” with some specified exceptions.

A “designated record set” means a group of records that are used by or for us to make decisions about you, including: enrollment, payment, reimbursement and case or medical management records.

You must make your request in writing to access copies of your records, and provide the Plan Administrator with the specific information needed to fulfill your request.

Amendment of PHI – You have the right to ask that any PHI in a “designated record set” be amended. All requests for amendment must be in writing. The Plan Administrator will not amend records in the following situations:

- The Plan does not have the records you are requesting be amended.
- The Plan did not create the records that you are requesting be amended.
- The Plan Administrator has determined that the records are accurate and complete.
- The records have been compiled in anticipation of a civil, criminal or administrative action or proceeding.
- The records are covered by the Clinical Laboratory Improvement Act.

All denials will be made in writing. You may respond by filing a written statement of disagreement with the Plan Administrator, and the Plan Administrator would have the right to rebut that statement. The Plan Administrator will respond to a request to amend within 30 days of receipt of a written amendment request.

Accounting of Certain Disclosures – You have the right to an accounting of times when your PHI has been disclosed for any purpose other than the following:

- Treatment, payment or healthcare operations as described in this Notice;
- Disclosures that you or your personal representative have authorized; and
- Certain other disclosures, such as disclosures for national security purposes.
All requests for an accounting must be in writing. You must provide the Plan Administrator with the specific information needed to fulfill your request. This accounting requirement applies for 6 years from the date of disclosure, beginning with disclosures occurring after April 14, 2004.

**Disclosures to Family Members**

Your PHI will be shared with your family members or authorized representatives in one of two ways:

- You are present, either in person or on the telephone, and give us permission to talk to the other person, or
- You sign an authorization form.

**Additional Information**

For additional information, questions about this Notice, or if you want another copy, please write or call the Privacy Officer or Plan Administrator. Contact information is contained on the General Information page of this Summary Plan Description.

If you believe that your privacy rights have been violated, or if you disagree with a decision made by the Plan Administrator about access to your PHI, you may either:

- Call or write to the Privacy Officer.
- Notify the appropriate State regulatory agency to file a complaint.

If it is determined that your privacy rights have been violated, the Plan Sponsor will take appropriate disciplinary action against the individual or entity causing the violation.

The Plan Sponsor and Plan Administrator will not use or disclose PHI for employer-related actions or decisions or in connection with any other Plan Sponsor benefit or employee benefit plan. The Plan Sponsor will not take retaliatory action against you if you file a complaint about these privacy practices either with the Plan Sponsor, appropriate State agency or HHS.
GENERAL INFORMATION

Name of Plans: Colby Sawyer College Flexible Benefit Plan
Colby Sawyer College Health Care Reimbursement Plan
Colby Sawyer College Dependent Care Reimbursement Plan

Plan Sponsor, Plan Administrator and HIPAA Privacy Officer:
Colby Sawyer College
541 Main Street
New London, NH 03257
(603) 526-3740

For questions, or service of legal process contact the Plan Administrator above.

Employer Identification (Tax ID) Number: 02-0222120

Plan Number: 504

Type of Plan: The Flexible Benefit Plan is a cafeteria plan under Section 125 of the Internal Revenue code, allowing a choice between cash and certain qualified benefits.

Funding: The Plan is un-funded, with contributions and benefits paid out of the general assets of the Employer. No trust fund or other segregated fund has been established for this purpose. Reimbursement account benefits are entirely self-funded by the Employer through salary reduction contributions. The health coverage purchased through the Premium Conversion option of this plan is provided through insurance contracts.

Effective Date: February 1, 1990
Amended & Restated July 1, 2007

Plan Year: A Short Plan Year will run from July 1, 2007 to December 31, 2007, then in subsequent Plan Years from January 1 to December 31.

Claims Service Provider: Benefit Strategies, LLC
967 Elm Street, 4th Floor
PO Box 1300
Manchester, NH 03105-1300

APPENDIX A

Eligible Employee: Premium Conversion Plan - An employee who is regularly scheduled to work at least thirty (30) hours per week and work (9) month during the year.
Health Care Reimbursement Plan - An employee who is regularly scheduled to work at least twenty (20) hours per week and work (9) month during the year.
Dependent Care Reimbursement Plan - An employee who is regularly scheduled to work at least twenty (20) hours per week and work (9) month during the year.

Waiting Period: Premium Conversion Plan - Eligible employees may begin participation on the first day of the month following the date of hire as an Eligible Employee.
Health Care Reimbursement Plan - Eligible employees may begin participation on the first day of the month following the date of hire as an Eligible Employee.
Dependent Care Reimbursement Plan - Eligible employees may begin participation on the first day of the month following the date of hire as an Eligible Employee.
Insurance Plans Eligible for Premium Conversion:  
- Group Medical Insurance
- Group Dental Insurance

Over-The-Counter Drugs (OTC) Allowed: Yes

Benefit Credits: Benefit Credits are not available under the Plan. Benefits are provided solely through a combination of non-elective Employer contributions and Salary Reduction.

Maximum Salary Reduction Contributions:
- **Premium Conversion** – The amount necessary to pay the participant’s portion of the cost of benefits under the Premium Conversion Option.
- **Health Care Reimbursement Plan** – $3,000.00
- **Dependent Care Reimbursement Plan** – $5,000.00

Premium Conversion Election Process:
If you are contributing toward the cost of insurance plans eligible for Premium Conversion, you may participate in the Premium Conversion option by filing an election form with the Employer before the beginning of the Plan Year. Once the Premium Conversion option is elected, it will automatically remain in effect for each subsequent Plan Year unless you revoke it in writing by filing a waiver form with the Employer.

*FlexExpress® Card Eligibility and Provisions:*

The *FlexExpress®* Electronic Payment Card is available under the Health and Dependent Care Reimbursement Plans.

Extension Period:
Your Employer has adopted the 2 ½ Month Extension Period for the Health and Dependent Care Reimbursement Plans.