

Marshfield Clinic Health System, Inc.

Section 125 Salary Reduction Plan

(with Premium Conversion,
Health Flexible Spending Account,
and Dependent Care Plan)

Summary Plan Description

Effective April 1, 2023

Introduction

Marshfield Clinic Health System, Inc. (the Employer) sponsors the Marshfield Clinic Health System, Inc. Section 125 Salary Reduction Plan (With Premium Conversion, Health FSAs, and DCAP Components) (the Salary Reduction Plan) that allows eligible Employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pre-tax dollars.

This Summary describes the basic features of the Salary Reduction Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Salary Reduction Plan. If there is a conflict between the Salary Reduction Plan document and this Summary, then the Salary Reduction Plan document will control unless otherwise required by law.

Q-1. How do employees pay for benefits on a pre-tax basis? An Employee's election to pay for benefits on a pre-tax versus after-tax basis is made when enrollment into Medical and/or Dental Insurance Plan benefits, Health Flexible Spending Account or Dependent Care Plan is submitted. By electing the above benefits, you are electing to pay for benefits on a pre-tax basis. You agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator) for the Plan Year. See Attachment 1 regarding Life Changing Events.

Q-2. What benefits may be elected under the Salary Reduction Plan? The Salary Reduction Plan includes the following components:

- *Premium Conversion Component (Medical and Dental Insurance Benefits)*-permits an Employee to pay for his or her share of contributions for the Medical and Dental Insurance Plans with pre-tax dollars. Benefits provided generally under the Premium Conversion Component are called Premium Conversion Benefits.
 - Medical Insurance Plan means the major medical plan that the Employer maintains for Employees, their Spouses, and their Dependents, providing major medical-type benefits through a group insurance policy. Benefits provided under the Medical Insurance Plan are called Medical Insurance Benefits.
 - Dental Insurance Plan means the dental plan that the Employer maintains for Employees, their Spouses, and their Dependents, providing dental-type benefits through a separate group insurance policy. Benefits provided under the Dental Insurance Plan are called Dental Insurance Benefits.
 - Vision Insurance Plan means the voluntary vision insurance plan that is 100% employee paid and is offered to Employees, Spouses, and their Dependents. The vision insurance plan offers discounts on vision exams, frames and lenses and contact lenses. Benefits provided under the Vision Insurance Plan are called Vision Insurance Benefits.
- *Health Flexible Spending Arrangement (Health FSA) Component*-permits an Employee to pay for his or her qualifying Medical Care Expenses (defined in Q-23) that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits provided under the Health FSA are called Health FSA Benefits. As described in Q-23, the Health FSA election may be for:
 - Medical Expense (General-Purpose) Health FSA Coverage (MEFSA); or
 - Limited-Purpose (Vision/Dental/Post Deductible) Health FSA Coverage (LPFSA).
- *Dependent Care Assistance Program (DCAP) Component*-also called a dependent care flexible spending account-permits an Employee to pay for his or her qualifying Dependent Care Expenses (as described in Q-34) with pre-tax dollars. Benefits provided under the DCAP are called DCAP Benefits.

For purposes of the Medical, Dental and Vision Insurance Benefits, the terms Spouse and Dependent are defined as provided in the Medical, Dental and Vision Insurance Plan. For purposes of the other benefits, Spouse means a person of the same or opposite sex who is treated as a spouse for federal tax purposes. For purposes of the Health FSA, Dependent means (a) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year; and (b) your tax dependent under the Code except that an individual's status as a Dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition. See the Plan Administrator for more information about which individuals will qualify as your Spouse or Dependents.

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you.

Q-3. Who can participate in the Salary Reduction Plan? Employees in an active, benefit eligible status are eligible to participate in the Salary Reduction Plan. Elections in Workday must be completed within 31 days from start date or benefit eligibility date.

An Employee is an individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Employees do not, however, include (a) leased employees or individuals classified by the Employer as independent contractors, even if such an individual is later reclassified as a common-law employee; or (b) individuals who perform services for the Employer but who are paid by a temporary or other employment or staffing agency.

Q-4. What tax savings are possible under the Salary Reduction Plan? You may save federal and state income tax and FICA (Social Security) taxes by participating in the Salary Reduction Plan. How much an employee actually saves will depend on your total Salary Reduction Plan election, the total family income, and the tax deductions and exemptions claimed. Salary reductions also lower earned income, which can impact the earned income credit for eligible taxpayers.

Q-5. When does participation begin and end in the Salary Reduction Plan? Enrollment must be submitted by completing an electronic Workday enrollment event. An Eligible Employee will have 31 days from their start date/benefit eligibility date to complete and submit their electronic election. Coverage will become effective the first of the month following the start date/benefit eligibility date. An eligible Employee who fails to complete and submit their electronic Workday enrollment event by the 31-day deadline will not be able to elect any benefits under the Salary Reduction Plan until the next Open Enrollment Period (unless a Change in Election Event occurs, as explained in Q-7).

Employees who actually participate in the Salary Reduction Plan are called "Participants." An Employee continues to participate in the Salary Reduction Plan until (a) the end of the Plan Year (b) termination of the Salary Reduction Plan; or (c) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason). See Q-8, Q-13, and Attachment 2 (found at the end of this Summary) for information about how termination of participation affects your Benefits.

Q-6. What is the Open Enrollment Period and the Plan Year? The Open Enrollment Period is the period during which you have an opportunity to enroll or re-enroll under the Salary Reduction Plan for the up-coming Plan Year. The Plan Year is the 12 months beginning on each April 1 and ending on March 31 for the Premium Conversion Plan dental insurance premium, the Health FSA, and the DCAP. You will be notified of the timing and duration of the Open Enrollment Period, generally will be a two-week period in March preceding the Plan Year.

Q-7. Can I change my elections under the Salary Reduction Plan during the Plan Year? Generally, you cannot change your election to participate in the Salary Reduction Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). During the Plan Year, there are several important exceptions to the irrevocability rule. See the various Change in Election Events that are described in Attachment 1 (found at the end of this Summary). Employees can change their elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply for the following Plan Year only.

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code (the Code), if necessary, to prevent the Salary Reduction Plan from becoming discriminatory within the meaning of the federal income tax law. If a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator will correct the mistake in the manner and to the extent that it deems administratively possible and otherwise permissible under applicable law. Such action by the Plan Administrator may include withholding any amounts due from your compensation.

Q-8. What happens if my employment ends during the Plan Year, or I lose eligibility for other reasons? If your employment with the Employer is terminated during the Plan Year, then your active participation in the Salary Reduction Plan will cease and you will not be able to make any more contributions to the Salary Reduction Plan for Medical or Dental Insurance Benefits, Health FSA Benefits or DCAP Benefits. The Medical and Dental Insurance Benefits will terminate as of the end of the month in which you last work. The Health FSA and DCAP Benefits will end as of the last work day.

For reimbursement of expenses from the Health FSA Account after termination of employment, see Q-25. For reimbursement of expenses from the DCAP Account after termination of employment, see Q-36.

Medical and Dental Insurance Benefits Participants, in a staff reduction status, upon election of COBRA continuation will be able to continue participating in the Premium Conversion Plan through the end of the month in which severance is exhausted or through the end of the Plan Year, whichever occurs first. If you are rehired within the same Plan Year and are eligible for the Salary Reduction Plan, then you may make new elections, provided that you are rehired more than 31 days after you terminated employment. If you are rehired within 31 days or less during the same Plan Year, then your prior elections will be reinstated.

If you cease to be an eligible Employee for reasons other than termination of employment, such as a reduction of hours, benefits will cease either as of the last day in a benefit eligible status (Health FSA and DCAP) or through the end of the month (Health and Dental Insurance Benefits).

Q-9. Will I pay any administrative costs under the Salary Reduction Plan? No. The cost is paid in part by the use of forfeitures, if any (see Q-27 and Q-38). The rest of the cost of administering the Salary Reduction Plan is paid entirely by the Employer.

Q-10. How long will the Salary Reduction Plan remain in effect? Although the Employer expects to maintain the Salary Reduction Plan indefinitely, it has the right to amend or terminate all or any part of the Salary Reduction Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Salary Reduction Plan be amended accordingly.

Q-11. Who is Diversified Benefit Services, Inc. (DBS)?

DBS is a third party administrator (TPA). They offer on-line claims filing services for flexible spending accounts. Marshfield Clinic Health System, Inc. has partnered with DBS for the purpose of processing FSA and DCAP reimbursement requests. They can be reached at 1-800-234-1229 or www.dbsbenefits.com. Reimbursement request forms, deadlines and a list of eligible FSA and DCAP expenses are available on their web site. Reimbursement requests are processed weekly and the reimbursement is deposited to your bank account (the same account your paycheck is deposited).

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

Medical and Dental Insurance Benefits. The applicable insurance company will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the plan). For more information about how to file a claim and for details regarding the medical and dental insurance companies' claims procedures, consult the claims procedures applicable under that plan or policy, as described in the plan document or summary plan description for the Medical or Dental Insurance Plan.

Claims Under the Premium Conversion Plan, Health FSA, or DCAP. If a claim for reimbursement under the Health FSA or DCAP Components of the Salary Reduction Plan is wholly or partially denied, or you are denied a benefit under the Salary Reduction Plan (such as the ability to pay for Medical or Dental Insurance, Health FSA, or DCAP Benefits on a pre-tax basis) due to an issue germane to your coverage under the Salary Reduction Plan (for example, a determination of a Change in Status; a "significant" change in contributions charged; or eligibility and participation matters under the Salary Reduction Plan document), then the claims procedure described below will apply.

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 31 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary; and
- appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals. If your claim under the Premium Conversion Plan, Health FSA, or DCAP is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Benefits Committee that acts on behalf of the Plan Administrator with respect to appeals (the Committee). Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review. Appeals under the Premium Conversion Plan, Health FSA, or DCAP will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under ERISA §502(a) (where applicable).

Claims Deadline. Unless otherwise provided under the Plan or required pursuant to applicable law, a claim for a benefits claim under the Premium Conversion Plan, Health FSA, or DCAP must be made within 60 days following loss of eligibility (termination, retirement, etc.) or the end of the year after the date the expense was incurred (whichever occurs first) that gives rise to the claim. You (or your designee, if applicable) are responsible for making sure this requirement is met.

Limitations Period for Filing Suit. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Premium Conversion Plan, Health FSA, or DCAP must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Q-13. What is Continuation Coverage, and how does it work?

COBRA. COBRA coverage is a continuation of health coverage that would otherwise end because of a life event known as a "qualifying event." See Attachment 2 (found at the end of this Summary) regarding COBRA coverage under the Health FSA Component, including when it may become available to you and your family and what you need to do to protect the right to receive it. See the booklets for the Medical and Dental Insurance Plans for information about COBRA continuation coverage under those plans.

USERRA. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the federal Uniformed Services Employment and Reemployment Rights Act (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

Q-14. How will participating in the Salary Reduction Plan affect my Social Security and other benefits? Participating in the Section 125 Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits, which are based on taxable compensation. However, the tax savings that you realize through Salary Reduction Plan participation will often more than offset any reduction in other benefits.

Q-15. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence. If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Medical and Dental Insurance Benefits and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage).

If you are going on paid FMLA leave and you opt to continue your Medical and Dental Insurance Benefits and Health FSA Benefits, your share of the contributions will be paid with pre-tax dollars by having such amounts withheld from the Participant's ongoing Compensation, including unused sick days and vacation days, or paying all or a portion of the Contributions on a pre-tax Salary Reduction basis out of post-leave Compensation.

If you are going on an unpaid FMLA leave and you opt to continue your Medical and Dental Insurance Benefits and Health FSA Benefits, your share of the contributions will be paid with pre-tax dollars out of post-leave Compensation or by other arrangements agreed upon by you and the Plan Administrator (for example, post-tax payment paid during the unpaid leave). Contributions from one calendar-year cannot be deducted from pre-tax post-leave compensation from a new calendar-year.

If you elect to stop your Medical Insurance Benefits, Dental Insurance Benefits, or Health FSA Benefits and DCAP Benefits coverage while you are on FMLA leave, you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. A new election must be completed in Workday within 31 days from your return to work date.

Non-FMLA Leaves of Absence. Benefits will cease either as of the last day of job-protected time or the end of the month in which job-projected time was exhausted. See Attachment 2 for COBRA continuation information.

Q-16. What are Premium Conversion Benefits? As described in Q-1, if you elect Medical and Dental Insurance Benefits you will pay for your share of contributions for Medical and Dental Insurance Benefits with pre-tax dollars. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal and state income taxes and FICA (Social Security) taxes. See Q-4. The only Premium Conversion Benefits offered under your Plan are for Medical and Dental Insurance Benefits.

Q-17. How are my Premium Conversion Benefits paid? As described in Q-1 and in Q-16, if you select the Medical and/or Dental Insurance Plans described in Q-16, then you will be required to pay a portion of the monthly premiums. Your share of the monthly premiums will be paid on a pre-tax basis. By electing the Medical and/or Dental Insurance Plans you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis.

Q-18. What are Health FSA Benefits? As described in Q-2, a Health FSA permits eligible Employees to pay for benefits with pre-tax dollars that will reimburse them for Medical Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from the Medical or Dental Insurance Plans).

As described in Q-1, if you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal and state income taxes and FICA (Social Security) taxes.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not reimbursed elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan. In the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, you may seek reimbursement from either the Health FSA or the HSA, but not both.

Q-19. What is my Health FSA Account? If you elect Health FSA Benefits, then an account called a Health FSA Account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

A Health FSA election may be for only one of the following:

- (a) Medical Expense General-Purpose Health FSA Coverage (MEFSA); or
- (b) Limited-Purpose (Vision/Dental/Post-deductible) Health FSA Coverage (LPFSA).

Note: If you elect Medical Expense General-Purpose Health FSA Benefits, you cannot also elect HSA Benefits or otherwise make contributions to an HSA unless you elect the Limited-Purpose (Vision/Dental/Post-deductible) Health FSA Coverage Option. If you elect the Medical Expense General-Purpose Health FSA Coverage Option, your Spouse (if you are married) and your Dependents will also be ineligible to make HSA contributions. Also see Q-21 regarding the impact of carryovers on HSA eligibility.

Q-20. What are the maximum and minimum Health FSA Benefits that I may elect, and how are these benefits paid for? You may choose any amount of Medical Care Expenses reimbursement that you desire under the Health FSA, subject to a minimum amount of \$100 and a maximum amount of \$2,650 per Plan Year. You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen.

When you complete the electronic Workday election event, you specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). For example, you have elected to be reimbursed up to \$1,000 for Medical Care Expenses and that you have chosen no other benefits under the Salary Reduction Plan. If you pay all of your contributions, then your Health FSA Account would be credited with a total of \$1,000 during the Plan Year. If you are paid biweekly, then your Health FSA Account would reflect that you have paid \$38.46 (\$1,000 divided by 26) each pay period in contributions for the Health FSA Benefits that you have elected.

The Employer makes no contribution to your Health FSA Account.

Q-21. What are Health FSA carryovers? You may carry over up to \$500 of unused amounts remaining in your Health FSA at the end of a Plan Year to be used for Medical Care Expenses incurred during the next Plan Year. (This applies only to the Health FSA; carryovers are not permitted under the DCAP.) No more than \$500 of your unused Health FSA amount for a Plan Year may be carried over for use in the next Plan Year.

Change for the 2015 Plan Year: Flexible Spending Account \$500 Carryover

Effective the 2015 plan year, the carryover of funds will not be contingent on a new election or a new election into the same spending account. The following assumptions will be made:

- The carryover will be added to the MEFSA if you are currently enrolled in the
 - MEFSA and you re-enroll in the MEFSA
 - MEFSA and you do not re-enroll in either plan
 - LPFSA and you enroll in the MEFSA
- The carryover will be added to the LPFSA if you are currently enrolled in the
 - LPFSA and you re-enroll in the LPFSA
 - LPFSA and you do not re-enroll in either plan
 - MEFSA and you you enroll in the LPFSA

IMPORTANT:

- ✓ In the event of a remaining balance, after the run out period³, participants can carryover up to \$500 into the new plan year. Balances in excess of \$500 will be forfeited.
- ✓ Carry over into a MEFSA will disqualify participants from contributing to a Health Savings Account (HSA) for the entire plan/calendar year.
- ✓ Funds carried over into a new plan will be subject to the terms and conditions of the new plan.
- ✓ Participation in the Clinic's HSA is dependent on being enrolled in a group High Deductible Health Plan.
- ✓ Participation in the LPFSA is dependent on being enrolled in the HSA with Fidelity Investments.
- ✓ MEFSA and LPFSA elections must be made during the March re-enrollment season, effective April 1.
- ✓ The \$500 carryover applies to the MEFSA and LPFSA plans only.
- ✓ The \$500 carryover does not apply to the Dependent Care Plan

History:

Marshfield Clinic Health System, Inc. approved the MEFSA and LPFSA carryover provision effective the 2014 plan year. Carryover of unused funds from the 2014 to the 2015 plan year was contingent on a new election into the same spending account for the 2015 plan year; MEFSA to MEFSA or LPFSA to LPFSA. Employees who failed to enter a new election into the same spending account for the 2015 plan year resulted in a loss of funds. Remaining funds could not be transferred to the other fund; MEFSA to LPFSA or LPFSA to MEFSA.

¹MEFSA – Medical Expense (General Purpose) Flexible Spending Account

²LPFSA – Limited Purpose Flexible Spending Account

³Run out period is the period of time during which participants can submit expenses incurred during the preceding plan year.

Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and they will not count toward the maximum dollar limit on annual salary reductions under the Health FSA (see Q-20).

Example: Assume that for 2018, you elect the maximum Health FSA Benefit amount permitted under the Plan. Your election will not affect your carryover, and you can also carry over the maximum permitted amount of \$500 from 2017 to 2018.

Termination of employment and cessation of eligibility will result in a loss of carryover eligibility.

Under IRS rules, if you carry over any unused Health FSA amounts to a General-Purpose Health FSA, you (and any other individual whose expenses can be reimbursed by your Health FSA) cannot contribute to an HSA during the entire next HSA Plan Year.

Q-22. What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year? The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). For example, you elected \$1,000 of coverage and contributed to your Health FSA Account (as described in Q-21) during January and February-that means that by February 24 you would have contributed \$153.84 (\$38.46 multiplied by 4 pay periods). On February 26 you incur a Medical Care Expense in the amount of \$300. You submit that claim for reimbursement on February 27. So long as the claim meets all applicable requirements, the \$300 would be available to you for that expense, even though you have only contributed \$153.84 to your Health FSA Account at that point. In future years, the amount of Health FSA coverage that is available to you will be increased by the amount of your carryovers, if any (see Q-21).

Q-23. What are Medical Care Expenses that may be reimbursed from the Health FSA? The eligible Medical Care Expenses vary according to the type of Health FSA coverage option that is elected, as described, in general, below.

(a) Medical Expense *General-Purpose Health FSA Coverage Option*. For purposes of the Medical Expense General-Purpose Health FSA Coverage Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code §213(d). However, expenses for medicines or drugs other than insulin will not qualify as Medical Care Expenses unless the medicine or drug has been prescribed.

See Diversified Benefits Services, Inc. portal for a list of eligible and non-eligible expenses.
www.dbsbenefits.com

(b) *Limited-Purpose (Vision/Dental/Post-deductible) Health FSA Coverage Option*. According to rules in Code §223 (applicable to HSAs), you will not be able to make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses Medical Care Expenses as described under the Medical Expense General-Purpose Health FSA Option (see subsection (a) above). You may, however, be eligible to make/receive tax-favored contributions to an HSA and participate in a Health FSA if the Health FSA reimbursement is limited to the Medical Care Expenses:

- Services or treatments for dental care (excluding premiums);
- Services or treatments for vision care (excluding premiums); or
- Post-deductible expenses.

See Diversified Benefits Services, Inc. portal for a list of eligible and non-eligible expenses.
www.dbsbenefits.com

Q-24. When must the Medical Care Expenses be incurred for the Health FSA? For Medical Care Expenses to be reimbursed to you from your Health FSA Account for a Plan Year, they must have been incurred during that Plan Year. The Plan Year for the Health FSA is the same as the Plan Year for the Salary Reduction Plan-it is the 12-month period beginning on April 1 and ending on March 31

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses incurred before the Health FSA or the Salary Reduction Plan became effective, before your electronic Workday election event became effective, or after a separation from service (except for continuation coverage, as described in Q-13 and Attachment 2, found at the end of this Summary). Expenses incurred during a subsequent Plan Year can only be reimbursed from your Health FSA Account for that Plan Year.

Q-25. What must I do to be reimbursed for Medical Care Expenses from the Health FSA? When you incur an expense that is eligible for payment, you must submit a claim to Diversified Benefit Services (DBS) at www.DBSbenefits.com. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Generally, this requires including an Explanation of Benefits (EOB) Form from the medical insurance carrier (or a bill from a doctor's office) indicating the amounts that you are obligated to pay. For medicines or drugs, you must provide an EOB, prescription, or receipt with an Rx number and the name of the purchaser or patient. Further details about what must be provided are contained on the DBS web site;
www.dbsbenefits.com.

If you have paid the contributions for the Health FSA coverage that you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the DBS Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control-see Q-11). Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected. See DBS web site for details regarding deadlines.

You will have until May 31 after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 60 days after the date you ceased to be eligible (last day of employment) in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible (last day of employment). You will be notified in writing if any claim for benefits is denied. (See Q-12.)

Prior to the May 31 deadline, Medical Care Expenses incurred during a Plan Year will be reimbursed first from your unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay your preceding Plan Year expenses, cannot exceed \$500, and will count against the \$500 maximum carryover amount. Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it.

To have your claims processed as soon as possible, please read Q-12. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense-only for you to have incurred the expense (as defined in Q-24) and that it is not being paid for or reimbursed from any other source.

Q-26. Is there any risk of losing or forfeiting the amounts that I elect for Health FSA Benefits? Yes. If the Medical Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for Health FSA Benefits (increased by any carryovers from the previous Plan Year, if applicable), you will forfeit any amounts that are not eligible for carryover to the following Plan Year as provided in Q-21. This is called the use-or-lose rule under applicable tax laws. The difference between what you elected (increased by any carryovers from the previous Plan Year, if applicable) and the Medical Care Expenses that were reimbursed will be forfeited at the end of the time limits described in Q-27 to the extent not carried over as provided in Q-21.

Q-27. What are the time limits that affect forfeiture of my Health FSA Benefits (and what happens to amounts that are forfeited)? You will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted by the May 31 following the end of the Plan Year for which the election was effective or carried over as provided in Q-21 (except that if you have ceased to be eligible as a Participant, you may forfeit such amounts at an earlier date-see Q-25). All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator). Also, any Health FSA Account benefit payments that are unclaimed (for example, bank account no longer available) by the close of the Plan Year (March 31) following the Plan Year in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

Q-28. Will I be taxed on the Health FSA Benefits that I receive? Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth in Q-20. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, then you will be required to repay the amount. Alternatively, the Plan Administrator may offset the amount against any other Medical Care Expenses submitted for reimbursement or withhold the amount from your pay.

Ultimately, it is your responsibility to determine whether any reimbursement under the Health FSA constitutes Medical Care Expenses that qualify for the federal income tax exclusion. Ask DBS (1-800-234-1229) or the Plan Administrator if you need further information about which expenses are-and are not-likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-29. What are DCAP Benefits? As described in Q-2, a DCAP permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your Spouse's DCAP).

As described in Q-1, if you elect DCAP Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal and state income taxes and FICA (Social Security) taxes.

Q-30. What is my DCAP Account? If you elect DCAP Benefits, an account called a "DCAP Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions for such benefits that you have paid during the Plan Year. Your DCAP Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

Q-31. What are the maximum and minimum DCAP Benefits that I may elect under the Salary Reduction Plan? You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to the minimum reimbursement amount of \$100 and the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual DCAP contribution equal to the coverage level that you have chosen (e.g., if you elect \$3,000 in DCAP Benefits, you'll pay for the benefits with a \$3,000 salary reduction).

The amount of Dependent Care Expense reimbursement that you choose cannot exceed \$5,000 for a plan or calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code §129 when your election is made. The \$5,000 maximum will apply to you if:

- you are married and file a joint federal income tax return;
- you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the DCAP); (2) you furnish over half of the cost of maintaining the household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of the household; or
- you are single or the head of the household for federal income tax purposes.

If you are married and file a separate federal income tax return under circumstances other than those described above, then the maximum DCAP Benefit that you may exclude from your income under Code §129 is \$2,500 for a calendar year.

These maximums (\$5,000 or \$2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations, as described in Q-42 (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

Q-32 How are my DCAP Benefits paid for under the Salary Reduction Plan? When you complete the electronic Workday election event, you specify the amount of DCAP Benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). If you pay all of your contributions, then your DCAP Account will be credited with the portion of your gross income that you have elected to give up through salary reduction. These portions will be credited as of each pay period.

For example, suppose that you have elected to be reimbursed for \$2,600 per plan year for Dependent Care Expenses and that you have chosen no other benefits under the Salary Reduction Plan. Your DCAP Account would be credited with a total of \$2,600 by the end of the Plan Year. If you are paid biweekly, then your DCAP Account would reflect that you have paid \$100 (\$2,600 divided by 26) each pay period in contributions for the DCAP Benefits that you have elected.

The Employer makes no contribution to your DCAP Account.

Q-33. What amounts will be available for DCAP reimbursement at any particular time during the Plan Year? The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year. Using the example in Q-32, suppose that you incur \$1,500 of Dependent Care

Q-34. What are Dependent Care Expenses that may be reimbursed? Dependent Care Expenses means employment-related expenses incurred on behalf of a person who meets the requirements to be a Qualifying Individual, as defined below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

Each person for whom you incur the expenses must be a Qualifying Individual-that is, he or she must be:

- a person under age 13 who is your qualifying child under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
- your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
- a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition).

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child.

- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP Account.
- The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.
- The expenses are incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care. The expenses can also be incurred while you are working and your Spouse is sleeping (or vice versa), if one of you works during the day and the other works at night and sleeps during the day.
- The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least 8 hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center-that is, a facility (including a day camp) that receives payment for providing care to more than 6 nonresident individuals on a regular basis-the center must comply with all applicable state and local laws.
- The person who provided care was not your Spouse, a parent of your under-age-13 qualifying child (e.g., a former spouse who is the child's noncustodial parent), or a person for whom you (or your Spouse) are entitled to a personal exemption under Code §151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight.
- The expenses can be for any of the following (assuming that the other requirements for reimbursement are met):
 - expenses for a day camp or a similar program to care for a Qualifying Individual, even if the camp specializes in a particular activity (e.g., soccer or computers), but excluding any separate equipment or similar charges (note that summer school and tutoring program expenses don't qualify because they are considered to be primarily for education rather than for care);
 - the cost of a Qualifying Individual's transportation to or from a place where care is provided, if furnished by a dependent care provider; and
 - expenses such as application fees, agency fees, and deposits that relate to but are not directly for a Qualifying Individual's care, if you must pay the expenses in order to obtain the related care (expenses of this type cannot be reimbursed unless and until the related care is provided-e.g., a deposit that is forfeited because you decide to send your child to a different dependent care provider is not eligible for reimbursement).

See Diversified Benefits Services, Inc. portal for additional information. www.dbsbenefits.com

You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit. Your statutory limit is the smallest of the following amounts:

- your earned income for the calendar year (after your salary reductions under the Salary Reduction Plan);
- the earned income of your Spouse for the calendar year (your Spouse is deemed to have earned income of at least \$250 (\$500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care (provided that you and your Spouse have the same principal place of abode for more than one-half of such year), or (b) a full-time student); or
- either \$5,000 or \$2,500 for the plan and calendar year, depending on your marital and tax filing status, as described further in Q-39.

Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a DCAP, the maximum amount that you and your Spouse together can exclude from income is \$5,000.

Q-35. When must the Dependent Care Expenses be incurred? For Dependent Care Expenses to be reimbursed to you from your DCAP Account for the Plan Year, the expenses must have been incurred during that Plan Year. The Plan Year for the DCAP is the same as for the Salary Reduction Plan-it is the 12-month period beginning on April 1 and ending on March 31.

A Dependent Care Expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for dependent care that will be given during the rest of the month, then the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the DCAP or Salary Reduction Plan became effective, for any expenses arising before your electronic Workday election event became effective, for any expenses incurred after the close of the Plan Year or after a separation from service (except as described in Q-36).

Q-36. What must I do to be reimbursed for my Dependent Care Expenses? When you incur an expense that is eligible for payment, you must submit a claim to DBS on a DBS DCAP Reimbursement Request Form available on the DBS web site; www.dbsbenefits.com. See DBS web site for additional details.

If there are enough credits to your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the DCAP Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control-see Q-12). If a claim is for an amount larger than that remaining in your current DCAP Account balance, then the excess part of the claim will be carried over into the following pay periods, to be paid out as your balance becomes available. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your DCAP Account.

You will have until May 31 after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 60 days after the date you ceased to be eligible in which to submit a claim for reimbursement for Dependent Care Expenses incurred prior to the date you ceased to be eligible. You will be notified in writing if any claim for benefits is denied. (See Q-12.)

Note that it is not necessary for you to have actually paid the bill in an amount due for a Dependent Care Expense, only for you to have incurred the expense (as defined in Q-35 and that it is not being paid for or reimbursed from any other source.

Q-37. Is there any risk of losing or forfeiting the amounts that I elect for DCAP Benefits? Yes. If the Dependent Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for DCAP Benefits, you will forfeit the rest of that amount in your DCAP Account. (Carryovers are not available under the DCAP.) This is called the use-or-lose rule under applicable tax laws. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Dependent Care Expenses during the Plan Year, even if amounts are still left in your DCAP Account. The difference between what you elected and what Dependent Care Expenses were reimbursed will be forfeited at the time periods described in Q-38.

Q-38. What are the time limits that affect forfeiture of my DCAP Benefits? You will forfeit any amounts in your DCAP Account that are not applied to DCAP Benefits for any Plan Year by the May 31 following the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you will forfeit such amounts if they have not been applied within 60 days after the date you ceased to be eligible-see Q-36). All forfeitures under this Plan shall be used to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator). In addition, any DCAP Account benefit payments that are unclaimed (e.g., bank account no longer available) by the close of the Plan Year (May 31) following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

Q-39. Will I be taxed on the DCAP Benefits I receive?

Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth in Q-31. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 (Child and Dependent Care Expenses) with your annual tax return (Form 1040) or a similar form. You must list on IRS Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount. Alternatively, the Plan Administrator may offset the amount against any other Medical Care Expenses submitted for reimbursement or withhold the amount from your pay. Ultimately, it is your responsibility to determine whether any reimbursement under the DCAP constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are-and are not-likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-40. If I elect DCAP Benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return? You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit (see Q-41). For example, if you elect \$2,000 in coverage under the DCAP and are reimbursed \$2,000, but you had Dependent Care Expenses totaling \$4,000, then you could count the excess \$2,000 when calculating the Dependent Care Tax Credit if you have two or more Qualifying Individuals.

Q-41. What is the Dependent Care Tax Credit? The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual Dependent Care Expenses. In determining what the tax credit would be, you may take into account \$3,000 of such expenses for one Qualifying Individual or \$6,000 for two or more Qualifying Individuals. For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 (Child and Dependent Care Expenses). You may also wish to consult a tax advisor, as discussed below.

Q-42. Would it be better to include the DCAP Benefits in my income and claim the Dependent Care Tax Credit, instead of treating the reimbursements as tax-free? For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. (And in some cases, the federal tax savings from participating in a DCAP will be only marginally better.) Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of Qualifying Individuals, earned income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 (Child and Dependent Care Expenses) to help you.

Q-43. What are my ERISA Rights? The Salary Reduction Plan and DCAP Components are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and the Medical and Dental Insurance Plans are governed by ERISA. Note: This Summary Plan Description does not describe the Medical or Dental Insurance Plans. Consult the Medical and Dental Insurance Plan documents and the separate Summary Plan Descriptions for the Medical and Dental Insurance Plans.

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

- **Receive Information About Your Plan and Benefits**
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, 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 copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Marshfield Clinic Health System, Inc., as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

Continue your Medical and Dental Insurance Plan coverage (and, in some cases, your Health FSA coverage) for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under a group health plan, if you have creditable coverage from another plan. (This does not apply to the Dental Insurance Plan or Health FSA, which are "excepted benefits" under HIPAA.) You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Note: Certificates of creditable coverage are no longer required beginning December 31, 2014, because plans are not permitted to impose preexisting condition exclusions for any plan year beginning on or after January 1, 2014.

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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require Marshfield Clinic Health System, Inc., as Plan Administrator, to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (see Q-11), you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance 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 contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Privacy Rights

Under another provision of HIPAA, group health plans (including the Health FSA) are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies, including with regard to electronic PHI.

Q-44. What other general information should I know? This Q-44 contains certain general information that you may need to know about the Plan. Note: This Summary Plan Description does not describe the Medical or Dental Insurance Plans. Consult the Medical and Dental Insurance Plan documents and the separate Summary Plan Descriptions for the Medical and Dental Insurance Plans.

General Plan Information

Name: Marshfield Clinic Health System, Inc. Salary Reduction Plan.

Plan Number: 501.

Effective Date: April 1, 2017

Plan Year: April 1 – March 31

Type of Plan: Welfare plan providing medical and dental insurance benefits, health FSA benefits, and DCAP benefits.

Employer/Plan Sponsor Information

Marshfield Clinic Health System, Inc.
1000 North Oak Avenue
Marshfield WI 54449

Federal employee tax identification number (EIN): 46-1495343

Marshfield Clinic Health System, Inc. includes the following entities: Marshfield Clinic, Inc., Family Health Center of Marshfield Inc., Security Health Plan of Wisconsin, Inc., Lakeview Medical Center, Inc. of Rice Lake, and MCHS Hosptails, Inc.

Plan Administrator Information

Marshfield Clinic Health System, Inc.
Chief Human Resources Officer
Human Resources Office
1000 North Oak Avenue
Marshfield WI 54449
715-387-5097

The Plan Administrator appoints the Benefits Manager to keep the records for the Plan and to be responsible for the administration of the Plan. However, the Benefits Committee acts on behalf of the Plan Administrator with respect to appeals. The Benefits Manager will answer any questions that you may have about our Plan. You may contact the Benefits Manager at the above address for any further information about the Plan.

Funding Medium and Type of Plan Administration

The Health FSA Component is a group health plan. The health FSA and DCAP Components are self-funded by the Employer and are contract administration plans. A third-party administrator processes claims for these Components, but the Employer pays the claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of these Components. There is no trust for the Plan or any component.

Named Fiduciary

The named fiduciary for the Health FSA Component is:

Marshfield Clinic Health System, Inc.

1000 North Oak Avenue

Marshfield WI 54449

715-387-5097

Agent for Service of Legal Process

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

Marshfield Clinic Health System, Inc.

1000 North Oak Avenue

Marshfield WI 54449

Attention: Director of Human Resources

Qualified Medical Child Support Order

The Health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA §609(a). The Health FSA has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Medical and Dental Insurance Plan and HSA Documents and Information

This Summary Plan Description does not describe the Medical and Dental Insurance Plans. Consult the Medical and Dental Insurance Plan documents and the separate Summary Plan Descriptions for the Medical and Dental Insurance Plans.

Attachment 1

When Can I Change Elections Under the Salary Reduction Plan During the Plan Year? Participants can change their elections under the Salary Reduction Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Change in Election Event: Leaves of absence, including FMLA leave (defined in Q-15); Changes in Status; Special Enrollment Rights; Certain Judgments, Decrees, and Orders; Medicare or Medicaid; Changes in Cost; Changes in Coverage. Note that the Change in Election Events do not apply for all Benefits-applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative-see Q-7. Note also that no changes can be made with respect to Medical or Dental Insurance Benefits if they are not permitted under the Medical or Dental Insurance Plan, as applicable.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new electronic Workday election event within 31 days after the occurrence (or within 60 days after the occurrence in the case of a special enrollment right due to loss of eligibility for Medicaid or state children's health insurance program coverage, or eligibility for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the Medical Insurance Plan).

1. Leaves of Absence (*Applies to Medical and Dental Insurance Benefits, Health FSA, and DCAP Benefits*). You may change an election under the Salary Reduction Plan upon FMLA and non-FMLA leave only as described in Q-15.

2. Change in Status. (*Applies to Medical and Dental Insurance Benefits, Health FSA Benefits (as limited below), and DCAP Benefits.*) If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a Section 125 plan (including this Salary Reduction Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age; or
- a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status-Other Requirements. *(Applies to Medical and Dental Insurance Benefits, Health FSA Benefits (as limited below), and DCAP Benefits.)* If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for DCAP Benefits, the event may also affect eligibility of Dependent Care Expenses (as defined in Q-42) for the dependent care tax exclusion).

Election changes may be made to reduce Health FSA coverage during a Period of Coverage due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent. The Health FSA coverage will stop if a change in employment status occurs such that the Participant becomes ineligible for Health FSA coverage.

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

Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For accident and health benefits (here, the Medical and Dental Insurance Plans and Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year Section 125 plan that allows employees to elect any of the following: no medical coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no medical coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel medical coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

Gain of Coverage Eligibility Under Another Employer's Plan (Applies to Premium Conversion Benefit only) For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's health or dental insurance plans as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Salary Reduction Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

DCAP Benefits. With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a DCAP as part of its Section 125 plan. Mike elects to reduce his salary by \$2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the DCAP. This event constitutes a Change in Status. Mike's election to cancel coverage under the DCAP would be consistent with this Change in Status.

4. Special Enrollment Rights. (*Applies Only to Medical Insurance Benefits.*) In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance Benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which was previously furnished to you. Contact the Benefits Manager if you need another copy.) When a special enrollment right explained in those separate documents applies to your Medical Insurance Benefits, you may change your election under the Premium Conversion Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders. (*Applies to Medical and Dental Insurance Benefits but Not to Health FSA or DCAP Benefits.*) If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical or Dental Insurance Benefits you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. (*Applies to Medical Insurance Benefits, Dental Insurance Benefits, and Health FSA Benefits (as limited below), but Not to DCAP Benefits.*) If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's health coverage under the Medical or Dental Insurance Plan and/or your Health FSA coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's health coverage (here, Medical or Dental Insurance Benefits and/or Health FSA Benefits, as applicable).

7. Change in Cost. (*Applies to Medical Insurance Benefits, Dental Insurance Benefits, and DCAP Benefits (as limited below), but Not to Health FSA Benefits.*) If the cost charged to you for your Medical or Dental Insurance Benefits or DCAP Benefits significantly increases during the Plan Year, then you may choose to do any of the following:

- make a corresponding increase in your contributions;
- revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer;
- drop your coverage, but only if no other benefit package option provides similar coverage.

For these purposes, the Health FSA is not similar coverage with respect to the Medical or Dental Insurance Benefits; an HMO and a PPO are considered to be similar coverage (the Employer currently offers an HMO and a PPO); and coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage. If the cost of Medical or Dental Insurance or DCAP Benefits significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes:

- if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions;
- if you are enrolled in another benefit package option (such as the HMO option under the Medical Insurance Plan), you may change your election on a prospective basis to elect the benefit package option that has decreased in cost (such as the PPO option under the Medical Insurance Plan); or
- if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

The Plan Administrator generally will notify you of increases or decreases in the cost of Medical or Dental Insurance benefits; you generally will have to notify the Plan Administrator of increases or decreases in the cost of DCAP benefits.

The change in cost provision applies to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

8. Change in Coverage. (*Applies to Medical Insurance Benefits, Dental Insurance Benefits, and DCAP Benefits, but Not to Health FSA Benefits.*) You may also change your election if one of the following events occurs:

Significant Curtailment of Coverage. If your Medical or Dental Insurance Benefits or DCAP Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally—loss of one particular physician in a network does not constitute significant curtailment.) If your Medical or Dental Insurance Benefits or DCAP Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical or Dental Insurance Benefits coverage; you generally will have to notify the Plan Administrator of significant curtailments in DCAP Benefits coverage.)

Addition or Significant Improvement of Salary Reduction Plan Option. If the Salary Reduction Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

Loss of Other Group Health Coverage. You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

Change in Election Under Another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other Section 125 plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Salary Reduction Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other Section 125 plan or qualified benefits plan, which it does. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Salary Reduction Plan to replace the dropped coverage.

DCAP Coverage Changes. You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

9. Reduction of Hours. *(Applies to Only to Medical and Dental Insurance Benefits.)* If you were reasonably expected to average 30 hours of service or more per week and experience an employment status change such that you are no longer reasonably expected to average 30 hours of service or more per week, you may prospectively revoke your election for Medical/Dental Insurance Plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform that is effective no later than the first day of the second month following the month that includes the date the Medical/Dental Insurance Plan coverage is revoked.

10. Exchange Enrollment. *(Applies to Only to Medical Insurance Benefits.)* If you are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for Medical Insurance Plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of the Medical Insurance Plan coverage.

Attachment 2

COBRA Continuation Coverage Rights Under the Health FSA Component

Introduction

The following paragraphs generally explain COBRA coverage under the Health FSA Component, when it may become available to you and your family, and what you need to do to protect the right to receive it. The description of COBRA coverage contained in this Attachment applies only to the Health FSA Component of the Plan and not to any other benefits offered under the Plan or by the Employer. See the booklets for the Medical and Dental Insurance Plans for information about COBRA continuation coverage under those plans.

What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?"

COBRA Coverage May Become Available to "Qualified Beneficiaries." After a qualifying event occurs and any required notice of that event is properly provided to the Employer, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA Coverage Under the Health FSA Component

COBRA Coverage Is Offered Only in Limited Circumstances. COBRA coverage under the Health FSA Component will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year. *Health FSA COBRA Coverage Lasts Only Until the End of the Plan Year.*

All Qualified Beneficiaries Are Covered Together Under the Health FSA Unless Otherwise Elected. Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact the Employer for more information.

No Health FSA Open Enrollment. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

Who Is Entitled to Elect COBRA?

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

Qualifying Events for the Covered Employee. If you are an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

Qualifying Events for the Covered Spouse. If you are the spouse of an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your coverage under the Health FSA Component in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

If you are the Dependent child of an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason other than his or her gross misconduct; or
- you stop being eligible for coverage under the Plan as a Dependent (see Q-2).

Electing COBRA After Leave Under the Family and Medical Leave Act (FMLA). Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Health FSA Component during the leave. Contact the Employer for more information about these special rules.

When Is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage under the Health FSA Component to qualified beneficiaries. You need not notify the Employer of any of these qualifying events.

You Must Notify the Plan Administrator of Certain Qualifying Events by This Deadline. 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), a COBRA election will be available to you only if you notify the Employer in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

No COBRA Election Will Be Available Unless You Follow the Plan's Notice Procedures and Meet the Notice Deadline. In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form" (you may obtain a copy of this form from the Employer at no charge), and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the Employer during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Electing COBRA Coverage

How to Elect COBRA. To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and mail or hand-deliver it to the Employer. (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the Employer.) You may provide the Election Form only by mail or hand-delivery. Delivery by another method, including by fax or email, is not acceptable.

Deadline for COBRA Election. If mailed, your election must be postmarked (or if hand-delivered, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Independent Election Rights. Each qualified beneficiary will have an independent right to elect COBRA. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

Length of COBRA Coverage

COBRA coverage under the Health FSA Component is temporary and can last only until the end of the year in which the qualifying event occurred-see the section above entitled "COBRA Coverage Under the Health FSA Component."

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage under the Health FSA Component will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time; or
- the employer ceases to provide any group health plan for its employees.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 100% of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

Payment for COBRA Coverage

How Premium Conversions Must Be Made. Unless you are able to continue eligibility in the Salary Reduction Plan and pay your COBRA premiums on a pre-tax basis as described in Attachment 1, all COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When Premium Conversions Are Considered to Be Made. If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

First Payment for COBRA Coverage. If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial Premium Conversion equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer using the contact information provided below to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly Payments for COBRA Coverage. After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Employer will not send periodic notices of payments due for these coverage periods (that is, **we will not send a bill to you for your COBRA coverage-it is your responsibility to pay your COBRA premiums on time**).

Grace Periods for Monthly COBRA Premium Conversions. Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month so long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for reimbursement of a medical expense incurred while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children Born to or Placed for Adoption With the Covered Employee During a Period of COBRA Coverage. A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients Under QMCSOs. A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Notice Procedures

Warning

If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA.

Notices Must Be Written and Submitted on Plan Forms Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this SPD, and you may obtain copies from the Employer without charge). Oral notice, including notice by telephone, is not acceptable. Electronic (including emailed or faxed) notices are not acceptable.

How, When, and Where to Send Notices You must mail or hand-deliver your notice to: Benefits Manager, Marshfield Clinic Health System, Inc., 1000 North Oak Avenue, Marshfield WI 54449. However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand-deliver your notice to that address (if you do not have a copy of the Plan's most recent summary plan description, you may request one from the Employer). You may provide a notice only by mailing or hand-delivery. Delivery by another method, including by fax or email, is not acceptable.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice period is described in the paragraph above entitled "You must notify the plan administrator of certain qualifying events by this deadline.")

Information Required for All Notices Any notice you provide must include (1) the name of the Plan (Marshfield Clinic Health System, Inc. Salary Reduction Plan); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary/beneficiaries who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Employer that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Who May Provide Notices The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.