CSM CORPORATION

Benefit Plan

Plan Document

ARTICLE I
DESCRIPTION AND PURPOSE

1.1. Plan Name, Legal Status and Purpose

A. The Plan name is the "CSM CORPORATION Benefit Plan."

B. This instrument, together with the applicable Benefit Summaries, constitutes the Plan Document.

C. This Plan is intended to qualify as a "cafeteria plan" under Code Section 125.

D. The Medical FSA Benefit is intended to qualify as a self-insured medical reimbursement plan under Code §105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b).

E. The DCAP Component is intended to qualify as a dependent care assistance program under Code §129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

F. The purpose of this Plan is to permit Eligible Employees to choose to make Payroll Contributions on a pre-tax basis to pay for the applicable Qualified Benefits.

G. Although reprinted within this document, the following Benefits are separate plans for purposes of applicable provisions of HIPAA and COBRA administration and all reporting and nondiscrimination requirements imposed by Law:

- Medical FSA
- DCAP

H. In the event that the Benefits under the Plan are determined not to be separate plans, the Plan shall be designated as a hybrid entity for purposes of HIPAA, such that it shall be a covered entity only with respect to the Health FSA Component.

I. In no event shall Benefits under the Plan be provided in the form of deferred compensation.

1.2. Plan Benefits

The Qualified Benefits available under this Plan are:

Pre-Tax Premium Benefit – The Pre-Tax Premium component is intended to permit Eligible Employees to pay the Premiums for Company-Sponsored Health Insurance elected by the Eligible Employee on a pre-tax basis. The terms and conditions of the Company-Sponsored Health Insurance Coverage, including eligibility for coverage, the benefits provided, and eligibility for

benefits, are as provided in the plans or policies for the Company-Sponsored Health Insurance Coverage and are not governed by this Plan.

Medical Flexible Spending Account – The Medical FSA component is intended to qualify as a "self insured medical reimbursement plan" under Code section 105 and the Medical Expenses reimbursed from such Accounts are intended to be excludable from Participants' incomes under Code section 105(b).

Dependent Care Flexible Spending Account – The Dependent Care FSA component is intended to qualify as a "dependent care assistance plan" under Code section 129 and the Dependent Care Expenses reimbursed from such Accounts are intended to be excludable from Participants' incomes under Code section 129.

ARTICLE II
GENERAL DEFINITIONS AND INTERPRETATIONS

As used in this instrument, unless the context or applicable Qualified Benefit Section otherwise expressly indicates, the terms defined in this Plan will have the meaning given them in the applicable Summary, provided that each of the following terms shall have the meaning given below.

2.1. Affiliate or Affiliated Organization

The Employer and any other corporation, trade or business which is under common control with the Employer under the provisions of section 414 of the Code. Unless specifically provided otherwise, such corporation, trade or business shall be deemed an Affiliate for all purposes, only from the date it came under the common control with the Employer. The term Affiliate shall include for all purposes of this Plan an affiliated service group as defined in section 414(m) of the Code and any other entity required to be aggregated with the Employer pursuant to regulations under section 414(o) of the Code.

2.2. Account

A bookkeeping account to which Payroll Contributions are credited. A separate bookkeeping account is established for each Option elected by the Participant. A Participant's Account is charged as benefits are used.

2.3. Administrator or Plan Administrator

The person or entity performing the administrative activities of the Plan. To the extent the Plan Administrator has delegated administrative activities to the Claims Administrator, the term "Administrator" may mean Claims Administrator.

2.4. Annual Contribution Election

The amount elected by a Participant to be allocated to an Account for an entire Plan Year (or the Participant's Period of Coverage, if less than the Plan Year).

2.5. Claims Administrator

The person or entity performing claims administration and other administrative activities on behalf of the Plan. The Claims Administrator is named in the Summary.

2.6. Claims Submission Period

The period stated in the Summary within which a claim must be submitted to the Claims Administrator to be eligible for reimbursement.

2.7. COBRA

ERISA sections 601 through 608 and section 4980B of the Code.

2.8. Code or Internal Revenue Code

The Internal Revenue Code of 1986, as amended. Any reference to a section of the Code refers to that section of the Internal Revenue Code of 1986, or the corresponding section of the Code as amended from time to time.

2.9. Company

The company identified in the Summary and its successors and assigns.

2.10. Company-Sponsored Health Insurance or Company-Sponsored Health Insurance Coverage

Coverage an employee has elected under a Company-sponsored health plan, whether insured through an insurance company or self-insured by the Company (benefits paid from general corporate assets), excluding the Medical FSA. The Company-sponsored health plans are listed in the Summary.

2.11. Compensation

The amount that, if the Participant did not participate in the Plan, would be reportable by the Employer as the Participant's "wages" for such period for federal income tax purposes, excluding non-cash benefits and any items not payable on a regular payroll date basis.

2.12. Debit Card

A card issued by the Administrator which permits conditional reimbursements for medical expenses to occur at the time the expense is incurred. A Participant is obligated to comply with all terms and conditions imposed on the use of a debit card and the expense must qualify as a Medical Expense under the terms of the Plan.

2.13. Dependent

Generally, a person who qualifies as a "dependent' of the Participant under the relevant provision of the Code. The requirements that must be met for a person to qualify as the Participant's dependent differ depending on the type of benefit. See applicable Benefit Option section.

2.14. Election Change Event

An event permitting an election change as outlined in the Plan.

2.15. Eligible Employee

An Employee who meets the eligibility requirements stated in the applicable Summary.

No judicial or administrative reclassification or reclassification by the Employer, of a person as a common-law employee or otherwise Eligible Employee will be applied to grant retroactive eligibility to any person under this Plan.

2.16. Eligible Expense

An expense that meets all of the requirements to be eligible for reimbursement under the Plan and the applicable Option.

2.17. Employee

An individual, who is employed by a Participating Employer, classified by the Employer as a common-law employee under the Employer's employment and payroll practices and employed within the United States or is a United States expatriate.

2.18. Employer or Participating Employer

The Company or any Affiliated Organizations and their successors and assigns, if any, that have adopted the Plan with the Company's consent. Any of those entities may be considered the "Employer" when that term is used in the Plan. The plural use of the term will include the Company and all those participating employers.

2.19. ERISA

The Employee Retirement Income Security Act of 1974, as amended from time to time.

2.20. Excluded Individual

An individual excluded from participation in the Plan as stated in the Summary. An Excluded Individual cannot be an Eligible Employee.

2.21. FMLA Leave

A leave of absence taken by a Participant pursuant to the Family and Medical Leave Act of 1993, as amended from time to time.

Grace Period

The period specified in the Summary, and not exceeding 2 ½ months, immediately following a Plan Year. Eligible Expenses incurred during a Grace Period may be reimbursed from the Carryover Amount from the prior Plan Year.

2.22. High Deductible Health Plan or HDHP

A health plan described in Code section 223(c)(2).

2.23. HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended.

2.24. HSA or Health Savings Account

A tax-favored individual account to be used in conjunction with a High Deductible Health Plan to pay Medical Expenses not covered by the High Deductible Health Plan.

2.25. Medical Expense

An expense incurred by the Participant for medical care within the meaning of Code section 213(d) for the Participant or his or her spouse or Dependent that is eligible for reimbursement pursuant to the applicable Code section and regulations, Option Summary and Plan Rules.

2.26. Open Enrollment or Open Enrollment Period

The period preceding each Plan Year, as designated by the Plan Administrator, during which Eligible Employees may make elections for Plan benefits to be effective for such Plan Year.

2.27. Option or Benefit Option

A Qualified Benefit under this Plan.

2.28. Other Health Insurance or Other Health Insurance Coverage

Individual or group health plan coverage (whether insured through an insurance company or self-insured) for the employee, his or her spouse, and his or her Dependents, obtained by the employee or his or her spouse.

2.29. Participant

An Eligible Employee who has satisfied any Service Requirement and enrolled in the Plan in the manner required by the Plan Administrator.

2.30. Payroll Contributions

Participant contributions for benefits elected under the Plan taken from the Participant's Compensation.

2.31. Payroll Period

A payroll period of the Employer in which, under the Employer's standard payroll practices, charges for Plan benefits payable by an Eligible Employee are normally deducted from his or her pay.

2.32. Period of Coverage

The period during a Plan Year in which a Participant is covered under the Plan. When participation ends, the Participant's Period of Coverage will also end unless the Participant continues coverage as provided under the Plan.

2.33. Plan

The Company's Further Flexible Benefit Plan, as amended from time to time.

2.34. Plan Rules

Rules established by the Plan Administrator or Claims Administrator with respect to administration of the Plan. The Plan Administrator or Claims Administrator may implement or change a Plan Rule by a written instrument or by practice without prior notice to any person**.**

2.35. Plan Year

The annual period indicated in the Summary.

2.36. Premium

The amount that, without regard to this Plan, would be required to be paid by a Participant for Company-Sponsored Health Insurance Coverage elected by the Participant or Other Health Insurance Coverage obtained by the Participant. To be covered, Premiums must be eligible for payment pursuant to the applicable Code section and regulations, Option Summary and Plan Rules.

2.37. Pre Tax Premium Benefit or Pre Tax Premium

The ability for a Participant to pay Premiums for Company Sponsored Health Insurance on a pre tax basis through this Plan.

2.38. Qualified Benefits

The benefits provided under this Plan that are listed in section 1.2.

2.39. Qualifying Election Change

An election change made due to an Election Change Event that is consistent with the election change as required by the Plan and IRS regulations.

2.40. Eligibility Requirement

The period an Eligible Employee must be employed before he or she is permitted to enroll in and participate in the Plan as stated in the Summary.

2.41. Similar Coverage Option

Coverage for the same category of benefits for the same individuals. The coverage can be provided under the plan of the Employer or the plan of a Participant's spouse's or Dependent's employer. This term is relevant with respect to change in cost or coverage Election Change Events.

2.42. Summary

The Summary document for a Benefit Option. The Summary serves as the Summary Plan Description for an ERISA-governed Option.

ARTICLE III
PARTICIPATION

3.1. Eligibility to Participate

All Eligible Employees who have satisfied the Service Requirements are eligible to participate in the Plan.

3.2. Terms and Conditions of Participation

The terms and conditions of participation, including commencement, termination, and continuation of participation, for an Option are as provided in the Summary for that Option.

ARTICLE IV
MEDICAL FLEXIBLE SPENDING ARRANGEMENT BENEFIT

4.1. Definitions

A. **Carryover Amount**

The amount specified in the Summary (if any).

B. **Dependent**

Includes: (i) your spouse (to whom you are legally married); (ii) a person whom you can claim as a dependent on your federal income tax return; and (iii) a child whom you can claim as your health care tax dependent within the meaning of Code sections 105 or 106. This includes your son, daughter, stepson, stepdaughter or foster child who was under the age of 26 at the beginning of the calendar year.

C. **HSA-Compatible Medical FSA**

A Medical FSA that only permits reimbursement of (A) vision and dental Eligible Medical Expenses; and/or (B) Eligible Medical Expenses once the deductible for the High Deductible Health Plan HSA been satisfied, as indicated in the Medical FSA Summary of Benefits.

D. **Medical FSA**

The flexible spending arrangement from which a Participant's Medical Expenses is reimbursed.

E. **Qualifying Election Change**

An election change made due to an Election Change Event that is consistent with the election change as required by the Plan and IRS regulations and as described in this Section.

4.2. Medical FSA Benefits

The Plan provides the Qualified Benefits selected in section 1.2. Additional terms and conditions applicable to each Option are as described in the Summary for the Option.

4.3. Funding of Plan Benefits

Election amounts will be funded through Participant Payroll Contributions made on a Payroll Period basis on behalf of Eligible Employees. Any remaining Compensation will be paid to the Participant in cash, subject to such other charges as may be imposed on such Compensation. No separate fund or trust is maintained to pay Plan benefits, all of which are paid from the general assets of the Company.

4.4. Employer Contribution

If an Employer contribution is made, the Employer will contribute an equal amount to each Participant in the same Eligible Employee category who participates the entire Plan Year, provided that contributions made for highly compensated employees, as defined by Code section 414(q), can be lower than non-highly compensated employees in the same Eligible Employee category. If a Participant's Period of Coverage is less than a Plan Year, the amount will be adjusted accordingly. The Employer contribution, if any, is stated in the Summary.

4.5. Participant's Account

A. An "Account," with respect to a Participant, is the bookkeeping reserve account or subaccount, as the context may require, used to track allocation and payment of Plan benefits.

B. The Administrator will establish and maintain an Account in the name of each Participant.

C. The Administrator will establish and maintain under each Participant's Account a subaccount for each Option elected by the Participant.

D. Each Participant's Account will be credited and debited in accordance with the remaining provisions of this Article.

4.6. Allocation to Accounts

Allocations to the Participant's Account will be made proportionately on a Payroll Period basis throughout the Plan Year (or the Participant's Period of Coverage, if less than the Plan Year) except as otherwise deemed appropriate by the Administrator.

4.7. Payments from Accounts

A. A Participant's Account will be debited with the amount of each payment of Medical FSA benefit. Payments will be debited as of the date they are made.

B. Reimbursements to Participants for the cost of Eligible Expenses from a Medical FSA will be made upon submission of a proper claim for reimbursement pursuant to the procedure described in the Summary. The Administrator may prescribe the minimum reimbursement amount that will be paid and the frequency and timing of reimbursement payments.

C. The full Annual Contribution Election to the Participant's Medical FSA for the Plan Year will be available to the Participant from the first day in the Plan Year on which he or she is a Participant.

4.8. Cash

A. The excess, if any, of (1) the amount of Payroll Contributions allocated to the Participant's Account on any payroll date over (2) the total allocation to the benefit sub-accounts on such date will be paid to the Participant in cash.

B. To the extent that an amount paid from the Participant's DCAP is includable in the Participant's gross income for federal income tax purposes, because it exceeds the earned income limitation of Code section 129(b), the Participant fails to comply with the reporting requirements of Code section 129(e)(9) or otherwise, such amount will be treated as a cash distribution to the Participant.

C. To the extent an amount paid from an Account is not permitted by the Code or regulations to be paid on a pre-tax basis, it will be treated as a cash distribution to the Participant.

4.9. Grace Period

A. A Participant's Carryover Amount, if any, will be available to reimburse Eligible Expenses incurred prior to the end of the Grace Period. Expenses incurred during the Grace Period will first be reimbursed from the Carryover Amount and then from contributions for the current Plan Year.

B. Any amount remaining in a Participant's Account at the end of the Grace Period will be forfeited in accordance with the manner described in this Grace Period section.

4.10. Forfeiture of Balance in Accounts

A. As of the end of the last day of each Plan Year or, if earlier, on termination of participation, the balance of each Participant's Account and subaccounts to which such period applies will be reduced to zero. This reduction will be made retroactively upon the expiration of the Claims Submission Period.

B. Forfeited amounts will be used by the Plan Administrator, in its discretion, to pay the cost of benefits under the Plan, for administrative costs of the Plan, or to provide additional benefits to Participants.

4.11. Status of Accounts

A. Accruing benefits under this Plan will not vest in a Participant any right, title or interest in or to any assets of the Company.

B. To the extent that benefits accrued to a Participant's Account are not paid when due, the Participant will become a general unsecured creditor of the Company.

C. None of the amounts credited to a Participant's Account will be considered to be held in trust or escrow or as any other form of asset segregation for any Participant.

D. Except for the unsecured contractual right to receive benefits payable under the Plan, no person shall have any right, title or interest in or to the assets of the Employer.

4.12. Distribution of Benefits upon Termination of Plan or Employee Participation

If the Company terminates the Plan, or an Employer terminates its participation in the Plan, each affected Participant's Account balance, as of the date of such termination, will continue to be

applied in the manner provided in the preceding provisions of this Article, but no allocations will be made to the Participant's Accounts following the date of such termination.

4.13. Benefit Elections

A. Each Eligible Employee desiring to participate in the Plan and each Participant will make Plan benefit elections in the manner prescribed by the Administrator.

B. The Administrator may impose conditions and limitations on the benefit elections, including the minimum and maximum election amounts, subject to any limitations imposed by law.

C. All Premiums for Company-Sponsored Health Insurance Coverage will be paid pre-tax, except to the extent required to be paid after-tax by the Code or provision of this Plan, unless the Plan Administrator permits Eligible Employees to opt out of participation and the Eligible Employee does so.

D. No Participant will be eligible to participate in the Pre-Tax Premium Benefit Account or Premium Reimbursement Account prior to the date on which the Participant first becomes covered under the Company-Sponsored Health Insurance or Other Health Insurance, as applicable.

E. Benefit elections will be made prospectively.

F. A Participant in the Medical FSA who has participating Company-Sponsored Health Insurance may elect to have the Company-Sponsored Health Insurance automatically submit requests for reimbursement of non-covered medical expenses, such as deductible amounts. This "crossover" election will remain in effect until the Participant notifies the Plan Administrator of the revocation of the election.

G. Eligible Employees who elect to participate in both the Plan's Medical FSA Benefit Option and the HSA Benefit Option for the same Plan Year will be limited to an HSA-Compatible Medical FSA. Eligible Employees who do not elect to participate in an HSA through this Plan may still choose to participate in the HSA-Compatible Medical FSA to maintain their eligibility and/or the eligibility of their spouses to participate in HSAs outside of this Plan.

4.14. Time of Election

A Participant's election with respect to a Plan Year will be made during the Open Enrollment Period for such Plan Year and will remain in effect for the entire Plan Year unless a Qualifying Election Change is made.

4.15. Deemed Election

A. An Eligible Employee who fails to make an election for the Premium Reimbursement Account, Medical FSA, Dependent Care FSA, or HSA during Open Enrollment or, with respect to a new Employee, during the time period provided the Summary, will be deemed to have elected no allocation for the Plan Year to such Accounts.

B. A Participant who experiences an Election Change Event but does not make a new election within the period provided in the Summary will continue the elections he or she had in effect prior to the Election Change Event.

4.16. Restrictions on Election Changes

A. An Annual Contribution Election is irrevocable during the Plan Year, except for certain Qualified Election Changes.

B. A Participant may make a Qualifying Election Change in the manner prescribed by the Plan Administrator and Claims Administrator and in accordance with the following rules:

1. An election will not be a Qualifying Election Change if the amount elected is less than the amount of reimbursements claimed from such Account for the Plan Year prior to the election.

2. The adjustment to the Participant's pre-tax contributions will not occur until the first payroll period after the Administrator receives, approves, and processes the Qualifying Election Change.

3. An election must be for prospective coverage only, except that in the case of an election change made to Company-Sponsored Health Insurance Coverage or Other Health Insurance Coverage as a result of a HIPAA special enrollment as a result of the birth, adoption, or placement for adoption of a child, the period of retroactive Company-Sponsored Health Insurance Coverage or Other Health Insurance Coverage required by HIPAA can be paid on a pre-tax basis.

C. Qualifying Election Change Events include change in status events, changes in cost or coverage events, and additional election change events:

1. A "change in status" event is:

a. a change in the Eligible Employee's marital status, including marriage, divorce, or death of a spouse;

b. a change in the number of the Eligible Employee's Dependents, including birth, adoption, placement for adoption or death of a Dependent;

c. an Eligible Employee's Dependent satisfies or fails to satisfy the Dependent eligibility requirements under a component plan;

d. a change in the employment status of the Eligible Employee or his or her spouse or Dependent, including termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, reduction or increase in hours, change in job location, or any other change in employment status that affects eligibility under an employer plan; or

e. a change in residence for the Eligible Employee or his or her spouse or Dependents.

2. The change in status event must affect eligibility for coverage under an employer plan and the election change under the employer plan must be on account of, and correspond with, the change in status event. A change in status event "affects eligibility for coverage" if it results in a gain or loss of eligibility for coverage, a change in the number of an Employee's family members who may benefit from the coverage.

3. Changes in cost or coverage events do not apply to the Medical FSA. The changes in cost and coverage events and the election changes that are permitted as a result of such events are as follows:

   a. a significant increase in the cost of a coverage option will permit a Participant to change to a Similar Coverage Option, and if one is not available, to cancel coverage;

   b. a significant decrease in the cost of a coverage option will permit a Participant or an Eligible Employee to elect that coverage option;

   c. the loss of a coverage option will permit a Participant to change to a Similar Coverage Option or, if one is not available, to cancel coverage;

   d. the reduction of coverage within a coverage option will permit a Participant who has that coverage option to change to a Similar Coverage Option;

   e. the addition or significant improvement of a coverage option will permit an Eligible Employee or a Participant to elect the new or improved coverage option; or

   f. an election change made under a plan of another employer, such as the plan of the employer of the Participant's spouse or Dependent, if either such other plan permits its participants to make an election change in accordance with the regulations under Code Section 125 or the Plan Year under this Plan and the plan year under such other plan are different will permit a corresponding election change under this Plan.

4. The following are additional election change events and the election changes permitted as a result of such events:

   a. The Participant may change his or her election in a manner that is consistent with a judgment, decree or order (including a qualified medical child support order) resulting from a divorce, legal separation, annulment or change in legal custody ("Order") that requires either that coverage be provided for the Participant's child under the Employer's health plan or that another individual provide health coverage for the child. The Participant can only elect to add coverage for the child under the

Employer's health plan if the child is a Dependent. The Participant can only elect to cancel coverage for the child under the Employer's health plan if the Order requires another individual to provide health coverage for the child and that coverage is actually provided.

b. The Participant may change his or her election in a manner that is consistent with the Participant's, the Participant's spouse's, or the Participant's Dependent's gain or loss of entitlement to Medicare (Part A or Part B) or Medicaid, other than coverage under the program for distribution of pediatric vaccines.

c. A Participant may change his or her election when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan Rules.

4.17. Limitations on Maximum Annual Contributions Imposed by Law

A. Medical FSA. The Maximum Contribution Election for the Medical FSA is limited to the indexed payroll contribution plan year limit as set by the Affordable Care Act (ACA).

B. The Plan Administrator can reduce an election that exceeds the Maximum Contribution Election to the Maximum Contribution Election.

4.18. Death of Participant

After the death of a Participant, benefits that would have been payable from the Participant's Account had the Participant survived will be paid to the Participant's spouse or dependents. If the Participant's spouse or dependents ARE eligible for and elect continuing coverage for Company-Sponsored Health Insurance, any amounts credited to the Pre-Tax Premium Account will be applied to reduce the cost of such continuing coverage. If no spouse or dependent is eligible to receive such payment, such payment will be made to the personal representative of the Participant's estate or to such other person whom the Administrator, in its sole discretion, determines to be legally entitled to such payment. Any payment so made will be a complete discharge of all liability under the Plan with respect to any such payment

ARTICLE V
DEPENDENT CARE FLEXIBLE SPENDING ARRANGEMENT BENEFIT

5.1. Definitions

A. **Dependent**

The term means a Qualifying Individual. The term "Qualifying Individual" will be defined and construed in accordance with Code sections 129 and 21

B. **Dependent Care Expense**

An expense a Participant incurs for dependent care provided to a Qualified Individual that meets all of the requirements necessary to be eligible for reimbursement under this Plan and the Dependent Care Plan.

C. **Dependent Care FSA**

The Account from which a Participant's Dependent Care Expenses is reimbursed.

D. **Dependent Care Plan**

The Company's Dependent Care Plan, as set forth in the Dependent Care FSA Summary and this Plan Document.

E. **Qualifying Election Change**

An election change made due to an Election Change Event that is consistent with the election change as required by the Plan and IRS regulations.

F. **Qualifying Individual**

In general, a Dependent of a Participant who is under the age of thirteen or a Participant's spouse or Dependent of any age who is physically or mentally incapable of self-care. A detailed definition of this term is provided in the Summary for the Dependent Care FSA. Only expenses incurred for the care of a Qualifying Individual are eligible for reimbursement from the Dependent Care FSA.

5.2. Benefit Elections

A. Each Eligible Employee desiring to participate in the Plan and each Participant will make Plan benefit elections in the manner prescribed by the Administrator.

B. The Administrator may impose conditions and limitations on the benefit elections, including the minimum and maximum election amounts, subject to any limitations imposed by law.

C. All Premiums for Company-Sponsored Health Insurance Coverage will be paid pre-tax, except to the extent required to be paid after-tax by the Code or provision of this Plan,

unless the Plan Administrator permits Eligible Employees to opt out of participation and the Eligible Employee does so.

D. No Participant will be eligible to participate in the Pre-Tax Premium Benefit Account or Premium Reimbursement Account prior to the date on which the Participant first becomes covered under the Company-Sponsored Health Insurance or Other Health Insurance, as applicable.

E. Benefit elections will be made prospectively.

5.3. Limitations on Maximum Annual Contributions Imposed by Law

A. Dependent Care FSA. The Maximum Contribution Election for the Dependent Care FSA cannot be greater than:

1. the maximum allowed by law.

2. the lesser of the Earned Income of the Participant and, if the Participant is married, the Earned Income of the Participant's spouse.

B. The Plan Administrator can reduce an election that exceeds the Maximum Contribution Election to the Maximum Contribution Election.

5.4. Time of Election

A Participant's election with respect to a Plan Year will be made during the Open Enrollment Period for such Plan Year and will remain in effect for the entire Plan Year unless a Qualifying Election Change is made.

5.5. Deemed Election

A. An Eligible Employee who fails to make an election during Open Enrollment or, with respect to a new Employee, during the time period provided in the Summary, will be deemed to have elected no allocation for the Plan Year to such Accounts.

B. A Participant who experiences an Election Change Event but does not make a new election within the period provided in the Summary will continue the elections he or she had in effect prior to the Election Change Event.

5.6. Death of Participant

After the death of a Participant, benefits that would have been payable from the Participant's Account had the Participant survived will be paid to the Participant's spouse or dependents. If the Participant's spouse or dependents are eligible for and elect continuing coverage for Company-Sponsored Health Insurance, any amounts credited to the Pre-Tax Premium Account will be applied to reduce the cost of such continuing coverage. If no spouse or dependent is eligible to receive such payment, such payment will be made to the personal representative of the Participant's estate or to such other person whom the Administrator, in its sole discretion,

determines to be legally entitled to such payment. Any payment so made will be a complete discharge of all liability under the Plan with respect to any such payment.

5.7. Restrictions on Election Changes

A. An Annual Contribution Election is irrevocable during the Plan Year, except for certain Qualified Election Changes.

B. A Participant may make a Qualifying Election Change in the manner prescribed by the Plan Administrator and Claims Administrator and in accordance with the following rules:

1. An election will not be a Qualifying Election Change if the amount elected is less than the amount of reimbursements claimed from such Account for the Plan Year prior to the election.

2. The adjustment to the Participant's pre-tax contributions will not occur until the first payroll period after the Administrator receives, approves, and processes the Qualifying Election Change.

3. An election must be for prospective coverage only.

C. Qualifying Election Change Events include change in status events, changes in cost or coverage events, and additional election change events:

D. A "change in status" event is:

1. a change in the Eligible Employee's marital status, including marriage, divorce, or death of a spouse;

a. a change in the number of the Eligible Employee's Dependents, including birth, adoption, placement for adoption or death of a Dependent;

b. an Eligible Employee's Dependent satisfies or fails to satisfy the Dependent eligibility requirements under a component plan;

c. a change in the employment status of the Eligible Employee or his or her spouse or Dependent, including termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, reduction or increase in hours, change in job location, or any other change in employment status that affects eligibility under an employer plan; or

d. a change in residence for the Eligible Employee or his or her spouse or Dependents.

e. The change in status event must affect eligibility for coverage under an employer plan and the election change under the employer plan must be on account of, and correspond with, the change in status event. A change in status event "affects eligibility for coverage" if it results in a gain or loss

of eligibility for coverage, a change in the number of an Employee's family members who may benefit from the coverage, or for the Dependent Care FSA, a gain or loss of eligibility for reimbursement of Dependent Care Expenses.

2. Changes in cost or coverage events does not apply when the change in cost is imposed by a provider who is related to the Participant. The changes in cost and coverage events and the election changes that are permitted as a result of such events are as follows:

3. a significant increase in the cost of a coverage option will permit a Participant to change to a Similar Coverage Option, and if one is not available, to cancel coverage;

   a. the loss of a coverage option will permit a Participant to change to a Similar Coverage Option or, if one is not available, to cancel coverage;

   b. the reduction of coverage within a coverage option will permit a Participant who has that coverage option to change to a Similar Coverage Option;

   c. the addition or significant improvement of a coverage option will permit an Eligible Employee or a Participant to elect the new or improved coverage option; or

   d. an election change made under a plan of another employer, such as the plan of the employer of the Participant's spouse or Dependent, if either such other plan permits its participants to make an election change in accordance with the regulations under Code Section 125 or the Plan Year under this Plan and the plan year under such other plan are different will permit a corresponding election change under this Plan.

4. A Participant may change his or her election for the Dependent Care FSA election when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan Rules

ARTICLE VI
PRE-TAX PREMIUM BENEFIT

6.1. Benefits Offered

The Pre-tax premium benefit is designed to permit Eligible Employees to choose to make Payroll Contributions on a pre-tax basis to pay for the applicable Qualified Benefits In no event shall Benefits under the Plan be provided in the form of deferred compensation.

6.2. Using Salary Reductions to Make Contributions

A. Salary Reductions per Pay Period. The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (as described in the corresponding 'Funding of Plan Benefits' Section of the 'Premium Payment Benefits' Article, 'Health FSA Benefits' Article, 'HSA Benefits' Article, and 'DCAP Benefits' Article, as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election under the Health FSA Component, HSA Component, or DCAP Component to the extent permitted under the 'Administrator's Discretion' Section of the 'Administration of Plan' Article, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to the 'Administrator's Discretion' Section of the 'Administration of Plan' Article, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

B. Considered Employer Contributions for Certain Purposes. Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits, Health FSA Benefits, HSA Benefits, and the DCAP Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

C. Salary Reduction Balance Upon Termination of Coverage. If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

D. After-Tax Contributions for Premium Payment Benefits. For those Participants who elect to pay their share of the Contributions for any of the Medical Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

6.3. Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Premium Payment Benefits, as described in 'Funding of Plan Benefits' Section of the 'Premium Payment Benefits' Article; and (b) as described under the 'Allocation of Employer Contribution Credits to Accounts' of the 'Health FSA Benefits' Article, the 'Using Salary Reductions to Make Contributions' of the 'HSA Benefits' Article, and paragraph (b) under the 'Enrollment' Section of the 'DCAP Benefits' Article.

6.4. Premium Payment Component

The Premium Payment Component offers benefits under the Medical Insurance Plan, providing major medical benefits (including a High Deductible Health Plan option and such other options as may from time to time be offered by the Employer), and the Dental Insurance Plan. Notwithstanding any other provision in this Plan, the Medical and Dental Insurance Benefits are subject to the terms and conditions of the Medical and Dental Insurance Plans, and no changes can be made with respect to such Medical and Dental Insurance Benefits under this Plan (such as midyear changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Medical and/or Dental Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component and pay for his or her share of the Contributions, if any, for Medical and Dental Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in the 'Administration of Plan' Article), such election is irrevocable for the duration of the Period of Coverage to which it relates. A Participant's Salary Reductions during a Plan Year under the Premium Payment Component may be applied by the Employer to pay the Participant's share of the Contributions for Medical and/or Dental Insurance Benefits that are provided to the Participant during the period that begins immediately following the close of that Plan Year and ends on the day that is 2 months plus 15 days following the close of that Plan Year.

6.5. Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.6. Benefits Provided Under the Medical and Dental Insurance Plans

Medical and Dental Insurance Benefits will be provided by the Medical and Dental Insurance Plans, not this Plan. The types and amounts of Medical and Dental Insurance Benefits, the requirements for participating in the Medical and Dental Insurance Plans, and the other terms and conditions of coverage and benefits of the Medical and Dental Insurance Plans are set forth in the Medical and Dental Insurance Plans. All claims to receive benefits under the Medical and Dental Insurance Plans shall be subject to and governed by the terms and conditions of the Medical and Dental Insurance Plans and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.7. Medical and Dental Insurance Benefits; COBRA

A. Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical and/or Dental Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical and/or Dental Insurance Plans the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

B. Contributions for COBRA coverage for Medical and Dental Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Medical and Dental Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

ARTICLE VII
ADMINISTRATION OF PLAN

7.1. Administrator, Named Fiduciary

The general administration of the Plan and the duty to carry out its provisions will be vested in the Company, which will be the "named fiduciary" of the Plan for purposes of ERISA, if applicable. The Company's Corporate Benefits Department will perform such administrative duties on behalf of the Company and may delegate all or any portion of such administrative duties to a named person and may from time to time revoke such authority and delegate it to another person. Each such delegation to a person who is not an employee of the Company will be in writing, and a copy will be furnished to the person to whom the duty is delegated. Such person will file a written acceptance with the Company's Corporate Benefits Department. Such person's duty will terminate upon withdrawal of such authority by the Company's Corporate Benefits Department or upon withdrawal of such acceptance by the person to whom the duty was delegated. Any such withdrawal will be in writing and will be effective upon delivery of a copy to the person to whom the duty was delegated or to the Company's Corporate Benefits Department, as the case may be. Any delegation to an employee of the Company will terminate when such individual ceases to be an employee or upon its earlier revocation by the Company's Corporate Benefits Department.

7.2. Administrator's Compensation

The Administrator, if an employee of the Company, will receive no compensation for services as Administrator but will be entitled to reimbursement by the Company for any amounts reasonably and necessarily expended in the performance of the Administrator's duties.

7.3. Administrator's Discretion

A. The Administrator has the sole, exclusive, absolute and complete discretionary power and authority with respect to administration of the Plan including, but not limited to, the discretionary power and authority to:

1. make all determinations (except those determinations which the Plan requires others to make) and to take all actions that the Administrator deems advisable for administration of the Plan, including entering into any contracts and administrative agreements;

2. construe, interpret, apply and enforce all Plan documents and to take or direct any course of action that the Administrator deems advisable to carry out the Plan's intent and purpose as determined by the Administrator;

3. decide all questions that arise that relate to the Plan and to make all factual determinations;

4. determine eligibility and coverage for participation and benefits;

5. establish and change the contributions required to be made for coverage under the Plan;

6. determine whether an individual is entitled to benefits and to decide the type, amount, manner of allocation and distribution of all benefits determined by the Administrator to be due and payable under the Plan;

7. remedy all defects, ambiguities, inconsistencies, omissions, and mathematical or arithmetical errors, including erroneous account balances; and

8. make or require rules, regulations, policies, and procedures that the Administrator deems advisable for the administration of the Plan and to change or modify any such rules, regulations, policies or procedures at any time.

B. Benefits under the Plan will only be paid if the Administrator decides in its discretion that an applicant is entitled to them.

7.4. Professional Assistance

The Administrator may retain such accounting, legal, clerical and other services as may reasonably be required in the administration of the Plan and may pay reasonable compensation for such services.

7.5. Reliance on Others

A. To the extent permitted by applicable law, the Administrator, the Company, the Employers, the board of directors and the officers of the Company or any other Employer may rely upon all certificates and reports made by an officer of the Company, and upon all reports and opinions within the area of expertise of, and given by, accountants, legal counsel and other professionals retained by them; and, to such extent, such persons will be fully protected with respect to any action taken or suffered by them in good faith in reliance upon any such certificates, reports and opinions and all actions so taken or suffered will be conclusive upon each of them and upon all Participants.

B. The Administrator will be entitled to rely upon any data or information furnished by the Company, any other Employer, or by a Participant as to age, service and compensation of any person, and as to any other information pertinent to any calculation or determination to be made under the provisions of the Plan and, as a condition to payment of any benefit under the Plan, may request any Participant to furnish such information as the Administrator deems necessary or desirable in administering the Plan.

7.6. Indemnification

The Participating Employers jointly and severally agree to indemnify and hold harmless, to the extent permitted by law, each director, officer, and employee of the Company and any Affiliated Organization against any and all liabilities, losses, costs and expenses (including legal fees) of every kind and nature that may be imposed on, incurred by, or asserted against such person at any time by reason of such person's services in connection with the Plan, but only if such person did not act with gross negligence, intentional misconduct, in bad faith or in willful violation of the law or regulations under which such liability, loss, cost or expense arises. The Participating Employers will have the right, but not the obligation, to select counsel and control the defense and settlement of any action for which a person may be entitled to indemnification under this provision.

7.7. Reports to Participants

Within a reasonable time after the end of each Plan Year and at such other times as the Administrator deems necessary or desirable, the Administrator will provide a report to each Participant of the status of his or her Account.

7.8. Claim Procedure

The Claims and Appeal procedure is described in the Summary for each Option.

7.9. Fiscal Records

The fiscal records of the Plan are maintained on a Plan Year basis.

ARTICLE VIII
MISCELLANEOUS

8.1. Governing Law

Except to the extent that state law has been preempted the Code or any other laws of the United States, as amended from time to time, this Plan will be administered, construed and enforced according to the laws of the State of MN.

8.2. HIPAA Privacy and Security

The HIPAA privacy and security rules are stated in Appendix A and only apply to the Premium Reimbursement Account and Medical FSA Benefit Options

8.3. Limitations on Actions

Notwithstanding any statutory limitations period or conflict of law provision, no action with respect to any Benefit under this Plan may be brought more than six months following the final decision in any appeal brought pursuant to the claim and appeal procedures set forth in this Plan.

8.4. Number and Gender

Wherever appropriate, the singular number may be read as the plural and the plural may be read as the singular and the feminine gender may be read as the masculine gender and the masculine gender may be read as the feminine gender.

8.5. Reference to an Officer of the Company

Any reference to a specific officer of the Company means the person who, from time to time, holds such office or, in the event that the name or function of such office is changed, such officer of the Company who succeeds to the functions of such office

8.6. No Employment Rights

Nothing contained in this Plan shall be construed as a contract of initial or continued employment between any Employee and the Employer, as a limitation of the right of the Employer to discharge any Employee with or without cause, or as an assurance of any benefit not expressly set forth in this Plan.

8.7. Severability

If any provision of this Plan is held to be illegal or invalid for any reason, that illegality or invalidity will not affect the remaining parts of this Plan. In such case, this Plan will be construed and enforced as if the illegal or invalid provision were not included in the Plan.

8.8. Withholding

Notwithstanding any contrary provision of this Plan, the Company or any other Employer may withhold from any payment charged against a Participant's Account such amounts as may be

required under sections 3102 and 3402 of the Code or under a similar law of any state, but will not be liable for any loss or damage incurred by a Participant on account of the Company's or other Employer's failure to do so.

8.9. Non-Assignability of Benefits

No benefit under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to so anticipate, alienate, sell, transfer, assign, pledge, encumber or charge the same will be void, and no such benefit will in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of the person entitled to such benefit.

8.10. Disabled Participants

If the Administrator determines that any person entitled to receive any payment under this Plan is physically, mentally or legally incapable of receiving or acknowledging receipt of such payment, and no legal representative has been appointed for such person, the Administrator, in its discretion, may (but will not be required to) cause any sum otherwise payable to such person to be paid to such one or more as may be chosen by the Administrator from the following: the institution maintaining the person or the person's spouse, children, parents or other relatives by blood or marriage. Any payment so made will be a complete discharge of all liability under the Plan with respect to such payment.

8.11. Satisfaction of Claims

Any payment to or for the benefit of any Participant, legal representative or person chosen by the Administrator in accordance with the provisions of the Plan will, to the extent of such payment, be in full satisfaction of all claims against the Administrator and the Company, either of which may require the payee to execute a receipted release as a condition precedent to such payment.

8.12. Participant Tax Consequences

A. None of the Company, Plan Administrator, Claims Administrator and Employer makes any commitment, guarantee, warranty or other representation regarding a Participant's ability to exclude the benefits paid under this Plan from his or her gross income for federal, state or local income tax purposes.

B. If any benefits paid under this Plan are determined to be includable in income, the Participant has no recourse against the Company or Administrator and the Company and the Administrator accept no liability for any damages or losses, including penalties, suffered by the Participant.

C. It shall be the obligation of each Participant to determine whether each payment or other benefit under the Plan is excludable from the Participant's gross income for federal, state and local income tax purposes. Any Participant, by accepting the benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus interest and penalties.

8.13. Non-Discrimination

Federal tax laws impose a variety of "nondiscrimination requirements" that must be satisfied before benefits provided under the Plan can be provided to employees on a tax-free basis. The non-discrimination requirements are generally intended to restrict the amount of nontaxable benefits available to certain employees of the Company who are officers, directors, "key employees" or "highly compensated." If the Company believes that the Plan may violate Code requirements prohibiting discrimination in favor of such employees with respect to eligibility, availability of benefits or utilization of benefits, it may limit the amount of pre-tax contributions that certain Participants can make, reduce benefits payable to certain Participants or take such other action as it deems advisable to avoid or eliminate such violation.

ARTICLE IX
ADOPTION, AMENDMENT AND TERMINATION

9.1. Adoption and Termination by Affiliated Organization

A. An Affiliated Organization may adopt this Plan and become an Employer in the manner prescribed by the Administrator.

B. An Affiliated Organization may terminate its participation in the Plan by providing written notice to the Administrator.

9.2. Amendment Procedure

The Company reserves the right to amend the Plan at any time, to any extent that it may deem advisable, and without prior notice. Each amendment will be stated in a written instrument. The Plan will be deemed to have been amended as set forth in the instrument and all Participants and Employers will be bound by the amendment; provided, however, that no amendment will have any retroactive effect so as to deprive any Participant of any benefit already accrued by means of the occurrence of an event entitling the Participant to a payment under the Plan.

9.3. Termination Procedure

The Company reserves the right to terminate the Plan at any time and without prior notice. Termination will occur by written instrument.

APPENDIX A
HIPAA Privacy and Security

1. HIPAA Privacy

A. Purpose

This section is intended to comply with the Standards for Privacy of Individually Identifiable Health Information, Title 45, Parts 160 and 164, Subparts A and E, of the Code of Federal Regulations, promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91 ("Privacy Rule").

B. Definitions

The following definitions will apply to the provisions in this Article:

1. "Health Information" is any information that:

A. is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

B. relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

2. "Health Care Operations" means the administration and operation of the Plan, including:

A. conducting quality assessment and improvement;

B. accreditation, certification, licensing, or credentialing;

C. underwriting, premium rating, and the placement of stop loss coverage;

D. conducting or arranging for medical review, legal services, and auditing;

E. cost-management and planning related to operation and management of the Plan;

F. management activities related to Privacy Rule compliance;

G. resolution of grievances; and

H. Plan activities resulting from sale, transfer, merger, or consolidation.

3. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91.

4. "Individually Identifiable Health Information" is Health Information created or received by the Plan or the Employer that:

   A. relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

   B. identifies the individual directly or reasonably could be used to identify the individual.

5. "Payment" includes activities undertaken to obtain contributions, determine or fulfill responsibility for coverage and benefits, or obtain or provide reimbursement for health care expenses; including, but not limited to:

   A. determinations of eligibility for coverage;

   B. coordination of benefits;

   C. claims adjudication;

   D. subrogation;

   E. claims management;

   F. collection activities;

   G. obtaining payment under a stop loss contract;

   H. medical necessity reviews;

   I. utilization review activities, including pre-authorization, pre-certification, concurrent and retrospective reviews;

   J. disclosure of certain information to consumer reporting agencies to collect premiums or reimbursement.

6. "Plan Administration Functions" are administration functions performed by the Administrator on behalf of the Plan, including Payment and Health Care Operations activities.

7. "Plan Sponsor" refers to the Company acting as Plan Sponsor as defined in at section 3(16)(B) of ERISA, codified as 29 U.S.C. 1002(16)(B).

8. "Privacy Rule" refers to the privacy regulations promulgated by the Department of Health and Human Services pursuant to HIPAA. The regulations are codified at 45 C.F.R. Part 164.

9. "Protected Health Information" or "PHI" is Individually Identifiable Health Information that is transmitted or maintained in any form or medium by the Plan.

C. Uses and Disclosures of Protected Health Information – Unless the subject individual authorizes a use or disclosure of PHI, the following restrictions will apply:

1. The Company may use PHI for Plan Administration Functions. The Company is currently involved with the following Plan administration activities: eligibility/enrollment, premium payment, Plan interpretation, receipt of Plan service provider reports, responding to Employee complaints and handling COBRA and Health Care Reimbursement Account administration in house. The Company may disclose PHI as permitted or required by the Privacy Rule or the privacy policies and procedures of the Plan.

2. The Company will not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law.

3. The Company will ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.

4. The Company will not use or disclose PHI for employment-related actions and decisions or in connection with any other Company benefit or employee benefit plan.

5. The Company will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware.

D. Certification Required to Disclose Protected Health Information to Company – The Plan will disclose PHI to the Company only upon receipt of a certification by the Plan Sponsor that the Plan Documents have been amended as required by the Privacy Rule.

E. Subject Individual Rights With Respect to PHI

1. The Company will make PHI available for access in accordance with the Privacy Rule section 164.524;

2. The Company will make PHI available for amendment and incorporate any amendments to PHI in accordance with Privacy Rule section 164.526; and

3. The Company will make PHI available required to make an accounting of disclosures required by Privacy Rule section 164.528.

F. Provide Information to the Department of Health and Human Services – The Company will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule.

G. No Longer Needed PHI – When any PHI received from the Plan ceases to be needed for the purpose for which it was disclosed, the Company will return or destroy such information maintained in any form and retain no copies of such information, except that, if return or destruction is not feasible, the Company will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

H. Adequate Separation between Plan and Company

1. The Company will provide adequate separation between the Plan and the Company in its capacity as other than the Administrator.

2. The Company designates the following employees, classes of employees, or persons to use and disclose PHI on behalf of the Plan for purposes of Plan Administration Functions: Human Resources.

3. Access to and use of PHI by the employees and other persons described in subsection (2) will be limited to the Plan Administration Functions that the Company performs for the Plan.

4. Those persons described in subsection (2) who fail to comply with the Privacy Rule or the Privacy Policies and Procedures of the Plan may be subject to disciplinary action up to and including termination.

2. HIPAA Security

A. Purpose – This Article is intended to comply with the Standards for Security Standards for the Protection of Electronic Protected Health Information, Title 45, Parts 160 and 164, Subpart C, of the Code of Federal Regulations, promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91.

B. Definitions – The following definitions will apply to the provisions in this Article:

1. “Availability” means the property that data or information is accessible and useable upon demand by an authorized person.

2. “Confidentiality” means the property that data or information is not made available or disclosed to unauthorized persons or processes.

3. “Electronic Media” means (1) storage in memory devices in computers or any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk or digital memory card; and (2) transmission media used to exchange information already in electronic storage media, including, for example, the internet, extranet, leased lines, dial-up lines, private networks and physical movement of removable/transportable electronic storage media.

4. “Electronic Protected Health Information” or “e-PHI” means Protected Health Information that is transmitted by, or maintained in, Electronic Media.

5. "Integrity" means the property that data or information have not been altered or destroyed in an unauthorized manner.

6. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification or destruction of e-PHI or interference with system operations in an information system containing e-PHI.

C. Administrative, Physical and Technical Safeguards – The Company will implement adequate administrative, physical and technical safeguards that will reasonably and appropriately protect the Confidentiality, Integrity and Availability of e-PHI that it creates, receives, maintains or transmits on behalf of the Plan.

D. Separation between Plan and Company – The Company will ensure that the adequate separation between the Plan and the Company in its capacity as other than the Administrator, as required by the "Adequate Separation of the Plan and Company" provision in the HIPAA Privacy Rule amendment to the Plan, is supported by reasonable and appropriate security measures.

E. Agents and Subcontractors – The Company will ensure that any agent, including a subcontractor, to whom it provides e-PHI received from the Plan agrees to implement reasonable and appropriate security measures to protect the e-PHI.

F. Security Incident Reports – The Company will report to the Plan any Security Incident of which it becomes aware that are not already known by the Plan.

CSM CORPORATION

Premium Only Plan

Pre-Tax Premium Summary

INTRODUCTION

CSM CORPORATION's Flexible Spending Plan (the "Plan") permits Eligible Employees to choose to pay for certain benefits on a pre-tax basis.

This *Summary* describes the Pre-Tax Premium Benefit, under which your Premium contributions for Health Insurance will be paid on a pre-tax basis. This will generally result in a tax savings and increase your spendable income.

The tax benefit you experience will depend on the benefit you elect, as well as other factors that affect the amount of taxes you pay. Although participating in the Plan can provide significant tax advantages, there may be tax disadvantages to participating in the Plan based on your particular situation. You may wish to consult with your tax advisor.

DETAILS REGARDING THE PRE-TAX PREMIUM BENEFIT

(a) **Pre-Tax Premium Benefit for Health Insurance:** The Plan permits your medical insurance premiums, including vision and dental (if applicable), to be paid on a pre-tax basis.

(b) **Pre-Tax Health Savings and Flexible Spending Account Elections:** The Plan permits the annual election amounts to be funded pre-tax through your payroll deduction.

(c) **Automatic Enrollment in Pre-Tax Premium Benefit:** If you elect health insurance coverage, you will automatically be enrolled in the Pre-tax Premium Benefit (unless you opt out of pre-tax premium payment for the coverage).

(d) **You are not required to request Reimbursement:** Pre-tax Premium Benefits will automatically be deducted from your paycheck before taxes are withheld and will be paid directly to the appropriate insurance company. You do not need to submit a claim for these expenses.

(e) **Changes to your Pre-Tax Premium may not correspond with changes to your Health Insurance:** If there is an insignificant change in your Premium for Health Insurance during the Plan Year, the Plan will automatically change the Premium contributions. For all other changes that you make to your health insurance, you will need to request that a corresponding election change be made to your Pre-Tax Premium. Only Qualifying Election Changes (see below) will be permitted. An election change permitted under the health insurance Coverage may not be permitted under this *Summary* or vice versa. While unlikely, it is possible for your Pre-Tax Premium Benefit to be less or more than your actual Premium payment amount due to an election change. If the Premium is more than the Pre-Tax Premium Benefit, you must pay the difference after-tax. If the Premium is less than the Pre-Tax Premium Benefit, you will forfeit the additional pre-tax payments made to your Account.

(f) **Health Insurance is separate from this Plan:** The terms and conditions of the health insurance, including eligibility for coverage, the benefits provided and eligibility for benefits, are as stated in the plans or insurance policies for the health insurance and are not governed by this Plan.

(g) **Company-Sponsored Health Insurance for Non-Tax Dependents:** Company-sponsored health insurance provided to you and your eligible family members is generally not subject to federal wage and income tax. Coverage provided for your family member who does not satisfy the IRS requirements to be considered your "health care tax dependent," however, is a taxable benefit. Your Employer is required to report to the IRS the fair market value of the coverage paid for by the Employer (or by you on a pre-tax basis) as taxable compensation on your W-2. When you enroll your family member in coverage and each time that you present your health plan card for services for the family member, you are certifying that your family member is your tax dependent for health care purposes. If your eligible family member is not your tax dependent, you must notify the Company's Human Resources Department. If you do not know whether your family member qualifies as your tax dependent, you should consult a tax advisor (such as an accountant).

ELIGIBLE EMPLOYEES

Only eligible employees may participate. An eligible employee may participate in the plan on the first of the month following 60 days of employment. You are eligible if you are:

- Employed by the company or a participating employer
- Regularly scheduled to work 30 or more hours per week
- Are not an excluded individual
- Satisfy any other eligibility requirements

You are a participant if you are an eligible employee, have enrolled in the Pre-Tax Premium Plan, and have not terminated participation.

Eligible employees do not include:

- Leased employees
- Independent contractors
- Employees subject to a collective bargaining agreement (except as specifically provided in the collective bargaining agreement)
- Interns

- Employees classified as temporary
- Employees covered by written agreements stating they are not eligible to participate in this Plan

DEPENDENTS

(a) For premiums to be paid on a pre-tax basis, such expenses must be incurred by you for yourself or a family member who qualifies as your "dependent."

(b) "Dependent" includes: (i) your spouse (to whom you are legally married); (ii) a person whom you can claim as a dependent on your federal income tax return; and (iii) a child whom you can claim as your health care tax dependent within the meaning of code sections 105 or 106. This includes your son, daughter, stepson, stepdaughter or foster child who was under the age of 26 at the beginning of the calendar year.

ENROLLMENT

If you elect health insurance, you will automatically be enrolled in the Pre-Tax Premium Benefit (unless you opt out of Pre-Tax Premium payment for the coverage).

WHEN PARTICIPATION BEGINS

Your participation begins on the first day of the Plan Year. Mid-year enrollment for new hires begins on the first of the month following 60 days of employment, enrollment must occur within 30 days of becoming an Eligible Employee.

ELECTION CHANGES DURING THE PLAN YEAR

(a) **Qualifying Election Changes:** Your election for any Plan Year cannot be changed during the Plan Year unless you experience an Election Change Event and make an election change that is on account of and consistent with the event (called a "Qualifying Election Change"). The Election Change Event must affect eligibility for your health insurance, your eligibility to participate in this Pre-tax Premium Account, or the eligibility of premiums for reimbursement (e.g. your child no longer qualifies as your tax dependent).

(b) **Examples:**

1. If the type of health insurance that you have changes because of your marriage, birth or adoption of a child, a corresponding increase to your Pre-Tax Premium Benefit will occur.

2. If you change your health insurance Coverage due to a divorce, because a child no longer qualifies as dependent, or a family member dies, a corresponding decrease to your Pre-Tax Premium Benefit will occur.

3. If your spouse or a dependent starts or ends a job or increases or decreases his or her work hours and gains or loses eligibility for employer-sponsored health insurance and you change your health insurance as a result, you can make a corresponding increase or decrease to your Pre-Tax Premium.

4. If a child is enrolled in or dropped from health insurance due to a court order that requires you or another person to provide health insurance, a corresponding change can be made to your Pre-Tax Premium.

5. If you, your spouse or your dependent gains or loses Medicare or Medicaid coverage and you change your health insurance as a result, a corresponding change can be made to your Pre-Tax Premium.

6. If you change your health insurance as a result of going on or returning from FMLA leave, a corresponding change can be made to your Pre-Tax Premium.

7. If there is a significant change in the cost or coverage of your health insurance and you change your health insurance election, a corresponding change can usually be made to your Pre-Tax Premium.

8. If a mid-year election change is made by your spouse or dependent under his or her health insurance or if your spouse's or dependent's employer's plan has a different plan year or period of coverage than this Plan, you may make a corresponding election change to your Pre-Tax Premium.

9. You may revoke your Pre-Tax Premium election for your employer-sponsored health coverage under the cafeteria plan if you purchased a Qualified Health Plan through a competitive marketplace established under ¬§1311 of the Patient Protection and Affordable Care Act, commonly referred to as an Exchange or a Health Insurance Marketplace (Marketplace).

10. You may revoke your Pre-Tax Premium election for your employer-sponsored health coverage under the cafeteria plan if your hours of service are reduced so that you are expected to average less than 30 hours of service per week but for whom the reduction does not affect the eligibility for coverage under your employer's group health plan.

(c) **Time Limit for Making Election Change:** To change your election, you must request an election change no later than 30 days* after the Election Change Event (even if you are on leave at the time). You cannot change your election more than 30 days* after an Election Change Event.

*There are only two exceptions to the 30-day limit. The Children's Health Insurance Program Reauthorization Act (CHIPRA) permits you to request an election change no later than 60 days after the loss of your or your dependent's Medicaid or CHIP coverage because of loss of eligibility or within 60 days after the date you or your dependent becomes eligible for a premium assistance subsidy under Medicare or CHIP.

(d) **Election Change Process:** The Plan Administrator will provide instructions for requesting an election change. The Plan Administrator will determine whether an election change is permitted.

PARTICIPATION DURING A LEAVE OF ABSENCE

Coverage will continue under this Plan during a leave of absence in accordance with the Company's leave policies and the terms and conditions of the Plan. If there is a conflict between the information provided in this section and the Company's leave policies, the Company's leave policies will control. Your leave must be approved by the Company.

You will be required to make your premium/contribution payments ("payments") for coverage to continue. If you do not make the required payment when due (including any grace period), the Company may retroactively terminate your coverage to the last day for which you have paid. Expenses incurred during the period for which your coverage is retroactively terminated will not be covered. The Company can recover any payments owed. Upon return to work, the payments owed will be taken from your pay.

Contact the Plan Administrator for coverage payment options.

(a) **Paid Leave of Absence:** Your Pre-Tax Premium Benefit will automatically continue during a leave of absence as long as you continue to receive pay.

(b) **Unpaid Leave of Absence:** Your right to continue group health plan coverage during unpaid leave depends on the type of leave. You should review the Company-Sponsored Health Insurance Summary Plan Description for the underlying details.

(c) **Open Enrollment during Your Leave:** If the open enrollment period for the next Plan Year occurs during your leave and your participation in the Plan continues, you will be able to make elections for Plan benefits for the new Plan Year in the same manner as active employees. If you do not make a new election for your group health plan coverage, the election in effect for the prior Plan Year will continue.

(d) **Making Election Changes on Return from Leave:** Election changes other than as noted in this section will not be permitted on return from leave unless you experience another Election Change Event and make the election change within 30 days of the event.

CLAIMS AND APPEAL PROCEDURES

(a) No Claims Submission Required: Pre-tax Premiums will automatically be deducted from your paycheck before taxes are withheld and will be paid directly to the appropriate insurance company. You do not need to submit a claim for these expenses.

(b) Written Request for Review: If your premium is not paid, you have the right to request review. You must send a written request for an appeal review to the Plan Administrator within 180 days of the denial of your Pre-Tax Premium Benefit. Your request for review should include the specific reason(s) you believe the premium should have been paid pre-tax through the plan.

(c) Right to Review Documents/Submit Comments: You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Plan Administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.

(d) Notice of Continued Denial: If the denial is upheld in whole or part, the Plan Administrator will notify you within 60 days after the Plan Administrator received your request for review. The notice will include the Plan Administrator's reason for its decision.

1. Level Two Appeal Process: Following the Level One Appeal Process, you have additional voluntary appeal rights through Further. If you are not satisfied with our decision, you may elect to further appeal to Further by sending a letter within 30 days or the later of your run out end date requesting our Appeals Committee to reconsider the decision. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or our customer service department. You have the option to present your concerns to the Appeals Committee either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.

2. You may elect this voluntary appeal (Level Two Appeal) only after you have submitted a Level One Appeal and that appeal has been denied. You are not required to submit a Level Two Appeal prior to bringing a claim in court (the plan will not assert that you failed to exhaust administrative remedies in not submitting to a Level Two Appeal). The six-month limitation period provided in the Plan Document within which you may bring a claim to court is tolled during the time that the Level Two Appeal is pending.

FORFEITURE OF ACCOUNT BALANCE

According to federal tax law, any amount remaining in your Pre-Tax Premium Accounts after the payment of eligible Premiums incurred during a Plan Year must be forfeited. Such forfeited amounts will be used by the Plan Administrator, in its discretion, to pay the cost of benefits under the Plan, for administrative costs of the Plan, or to provide additional benefits to participants.

TERMINATION OF PARTICIPATION DUE TO TERMINATION OF EMPLOYMENT

(a) **When Participation ends:** If your employment with the Company terminates, your participation in the Plan will end as of the date of your termination of employment.

(b) **Health Insurance Coverage after Termination:** Health insurance premiums incurred after the date of your termination from employment cannot be paid on a pre-tax basis through this Plan.

(c) **Re-employment by a Participating Employer:** If you terminate employment and are re-employed by a participating employer, you may participate in the Plan. Whether you are required to resume your elections in place prior to your termination or may make new elections depends on the length of time between your termination and reemployment and whether you are reemployed in the same Plan Year or a new Plan Year.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class within 30 days and within the same Plan Year will be required to resume participation in the Plan and the participant's prior benefit elections will be reinstated.

A Participant who terminates employment and is re-employed by a participating employer in an eligible employee class after 30 days or more and within the same Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

A Participant who terminates employment and is re-employed by a participating employer in an eligible employee class in a new Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

OTHER REASONS FOR TERMINATION OF PARTICIPATION

(a) Your participation in this Plan can also end if:

1. You no longer qualify as an Eligible Employee;

2. Your Employer stops participating in this Plan;

3. You commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan; or

4. The Company terminates the Plan.

(b) The rules discussed above for termination of participation as a result of termination of employment also apply if termination of participation occurs for other reasons.

NOTICES

(a) **ERISA, HIPAA and COBRA do not apply:** The Pre-Tax Premium Benefit is not an employee benefit plan within the meaning of ERISA and is not subject to ERISA, HIPAA or COBRA. The Company-Sponsored Health Insurance paid for on a pre-tax basis through this Plan, however, is subject to ERISA, HIPAA and COBRA. Please refer to the Company-Sponsored Health Insurance Summary Plan Description for your rights and responsibilities under those laws.

(b) **Company's Right to terminate or amend the Plan:** The Company reserves the right to amend or terminate the Plan at any time and without notice.

(c) **No Guarantee of Employment:** Participation in this Plan is not a guarantee of employment.

(d) **Plan Administrator's Discretion:** The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

PLAN SPECIFICATIONS

Employer, Plan Sponsor and Plan Administrator:

CSM CORPORATION
500 Washington Ave S Ste 3000
Minneapolis, MN 55415

Telephone: 612-395-7050

Claims Administrator:

Further
3535 Blue Cross Road
Eagan, MN 55122-1154
651-662-5065 or 800-859-2144
www.HelloFurther.com

Plan Year:

January 1 through December 31

CSM CORPORATION

Flexible Spending Plan

Medical FSA Summary

INTRODUCTION

CSM CORPORATION's Flexible Benefit Plan (the "Plan") permits Eligible Employees to choose to pay for certain benefits on a pre-tax basis.

This *Summary* describes the Medical Flexible Spending Account ("Company-sponsored") Benefit Option under the Plan. Through the Medical FSA, you can pay Medical Expenses not covered by insurance for yourself and eligible family members on a pre-tax basis. This will generally result in a tax savings and increase your spendable income.

Refer to our *FSA Essential Guide* for a tax savings example. You may also want to use the *Tax Savings Calculator* link available at https://learn.hellofurther.com/ to estimate your tax savings.

The tax benefit you experience will depend on the benefits you elect, as well as other factors that affect the amount of taxes you pay. Although participating in the Plan can provide significant tax advantages, there may be tax disadvantages to participating in the Plan based on your particular situation. You may wish to consult with your tax advisor.

DETAILS REGARDING THE MEDICAL FSA BENEFIT

(a) **Medical expenses eligible for reimbursement:** To be eligible for reimbursement, an expense must be for medical care provided to diagnose, treat, or prevent disease or for sickness or injury and must be included on the list of eligible medical expenses for this Benefit Option.

(b) **Employee Elections: Your minimum annual contribution is $100 per plan year. The maximum annual contribution for this benefit is the maximum allowed by the IRS. Note that salary reduction amounts from the last paycheck of the Plan Year may be used to pay for the first month of benefits elected for the next Plan Year.**

(c) **Employer Elections:**

The employer may contribute up to $500 to all eligible employees to enroll in their health plan without an employee contributing.

Employer may match dollar-for-dollar contributions (up to maximum allowed contribution determined by law) as long as the employee contributes the same amount. Employer contributions do not count toward the employee's maximum annual contribution.

When contributing an amount over $500, an employer's contribution cannot exceed the employee's election. For example, if the employee is contributing $1,000, the maximum employer contribution can only be $1,000 to the employee's FSA. When contributing an amount over $500, an employer's contribution cannot exceed the employee's election.

(d) **Expenses cannot be reimbursed from any other source, including tax credits or tax deductions:** Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud and you personally will be responsible for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.

(e) **Limitations for HSA and Medical FSA combination:** If you elect to participate in both the HSA and the Medical FSA benefits under this Plan, your Medical FSA is automatically limited to reimbursement of the following HSA-Compatible expenses: Vision and Dental; Post Deductible Medical. You may also choose to participate in an HSA-Compatible Medical FSA to maintain your eligibility and/or the eligibility of your spouse to participate in an HSA outside of this Plan. If you have not elected HSA coverage under this Plan, however, you must notify Further that you wish to participate in an HSA-Compatible Medical FSA.

ELIGIBLE EMPLOYEES

Only eligible employees may participate. You are eligible if you are:

- Employed by the company or a participating employer
- Regularly scheduled to work 30 or more hours per week
- Are not an excluded individual
- Satisfy any other eligibility requirements

You are a participant if you are an eligible employee, have enrolled in the Medical FSA Plan, and have not terminated participation.

Eligible employees do not include:

- Leased employees
- Independent contractors
- Employees subject to a collective bargaining agreement (except as specifically provided in the collective bargaining agreement)
- Interns
- Employees classified as temporary
- Employees covered by written agreements stating they are not eligible to participate in this Plan.

DEPENDENTS

(a) To use the Medical FSA for reimbursement of medical expenses incurred by you for yourself or a family member who qualifies as your "Dependent".

(b) "Dependent" includes: (i) your spouse (to whom you are legally married); (ii) a person whom you can claim as a dependent on your federal income tax return; and (iii) a child whom you can claim as your health care tax dependent within the meaning of Code sections 105 or 106. This includes your son, daughter, stepson, stepdaughter or foster child who was under the age of 26 at the beginning of the calendar year.

ENROLLMENT AND PARTICIPATION

(a) **Initial enrollment:** You must enroll within 30 days after becoming an Eligible Employee. Employees are eligible for this benefit on the first of the month following 60 days of employment at which time participation will begin. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement.

(b) **Annual open enrollment:** If you do not enroll when you are first eligible, you must wait until the next Open Enrollment Period for another chance to participate (unless you experience an "Election Change Event" and make a "Qualifying Election Change," as discussed later in this *Summary*). Federal tax law prohibits any other mid-year enrollment. The Open Enrollment Period for each Plan Year will be determined by the Plan Administrator.

(c) **Enrollment procedure:** The Plan Administrator will provide enrollment instructions. You must complete your enrollment within the time specified by the Plan Administrator.

(d) **Medical FSA election:** You must indicate the amount you want to contribute, if any, to a Medical FSA when you enroll.

(e) **Mid-Year Enrollment:** You must enroll within 30 days after becoming an Eligible Employee. Employees are eligible for this benefit on the first of the month following 60 days of employment, at which time participation will begin. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement

ELECTION CHANGES DURING THE PLAN YEAR

(a) **Qualifying election changes:** Your election for any Plan Year cannot be changed during the Plan Year unless you experience an Election Change Event and make an election change that is on account of and consistent with the event (called a "Qualifying Election Change"). For complete details, request a copy of the Plan Document from the Plan Administrator or contact the Claims Administrator for assistance.

(b) **Examples:**

1. If you get married, add a child to your family through birth or adoption or have a child who gains dependent status, you can increase your Medical FSA election.

2. If you divorce, a child no longer qualifies as your dependent, or your dependent dies, you can decrease your Medical FSA election.

3. If your spouse or a dependent starts or ends a job or increases or decreases his or her work hours and gain or lose eligibility for employer-sponsored health insurance or health flexible spending account coverage as a result, you can make a corresponding increase or decrease your Medical FSA coverage through this Plan.

4. If a court order requires you or another person to provide health coverage for an eligible child, a corresponding change can be made in your Medical FSA contributions.

5. If you, your spouse or your dependent gains or loses Medicare or Medicaid coverage, a corresponding change can be made in the contributions to your Medical FSA.

6. You may change your Medical FSA election when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan Rules.

(c) **You cannot elect an amount less than the amount already reimbursed:** An election change will not be consistent with an Election Change Event if the new amount elected is less than the amount already reimbursed from the Medical FSA for the Plan Year.

(d) **Time limit for making election change:** To change your election, you must request an election change no later than 30 days after the Election Change Event (even if you are on leave at the time). You cannot change your election more than 30 days after an Election Change Event.

(e) **Election change process:** The Plan Administrator will provide instructions for requesting an election change. The Plan Administrator will determine whether an election change is permitted.

PARTICIPATION DURING A LEAVE OF ABSENCE

General Rules: Coverage will continue under this Plan during a leave of absence in accordance with the Company's leave policies and the terms and conditions of the Plan. If there is a conflict between the information provided in this section and the Company's leave policies, the Company's leave policies will control. The Company must approve your leave.

You will be required to make your premium/contribution payments ("payments") for coverage to continue. If you do not make the required payment when due (including any grace period), the Company may retroactively terminate your coverage to the last day for which you have paid. Expenses incurred during the period for which your coverage is retroactively terminated will not be covered. The Company can recover any payments owed. Upon return to work, the payments owed will be taken from your pay.

Contact the Plan Administrator for coverage payment options.

(a) **Paid leave of absence:** Your Medical FSA coverage and your contributions for the coverage will automatically continue during a leave of absence as long as you continue to receive pay.

(b) **Unpaid leave of absence:** Your right to continue Medical FSA coverage during unpaid leave depends on the type of leave. If you do not elect to continue your Medical FSA coverage at the beginning of leave, you will not be able to submit medical expenses you incur during the leave for reimbursement. Rules regarding specific types of unpaid leave are as follows.

1. **FMLA Leave:** If you take FMLA leave, you may choose to continue or discontinue your Medical FSA coverage. You must notify the Company's Human Resources Department of your decision.

   i. If your Medical FSA coverage terminated, it will be reinstated on return from leave. You may choose to either reinstate the per pay-period contributions you had in place prior to leave (your contribution election for the Plan Year is reduced by the contributions you missed during your leave); or increase your per pay-period contributions for the rest of the Plan Year to make up the contributions you missed during your leave (your contribution election for the Plan Year remains the same).

   ii. Even if you choose to increase your per pay-period contributions to make up the contributions you missed during the leave, you will still not be able to submit expenses you incurred during the leave for reimbursement. (Medical expenses you incur during the leave will be eligible for reimbursement only if you elected to continue your Medical FSA in advance of your leave.)

2. **Military Leave:** If you go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may continue your group health plan and Medical FSA coverage for up to 24 months during the military leave to the extent required by USERRA. You must pay for the coverage. You may reinstate your coverage on return from leave to the extent required by USERRA. Contact the Company's Human Resources Department for more information.

3. **Other Types of Leave:** Contact the Plan Administrator for details. If your Medical FSA coverage terminates as a result of your leave, you may elect to continue your coverage through COBRA. Medical FSA COBRA rights are explained in the *Notice* section of this *Summary*. If you do not elect to continue your coverage through COBRA, you will not be eligible to recommence participation until the next Open Enrollment Period or you experience an Election Change Event.

(c) **Open enrollment during your leave:** If the Open Enrollment Period for the next Plan Year occurs during your leave and your participation in the Plan continues, you will be able to make elections for Plan benefits for the new Plan Year in the same manner as active employees. If you do not elect Medical FSA benefits, you will not be eligible to participate in the Medical FSA in the new Plan Year, unless you experience an Election Change Event.

(d) **Making election changes on return from leave:** Election changes other than as noted in this section will not be permitted on return from leave unless you experience another Election Change Event.

OBTAINING REIMBURSEMENTS

(a) **Amount available for reimbursement:** Regardless of the amount you have contributed to the Medical FSA, the entire amount of your contribution election for the Plan Year (your Annual Contribution Election) less any prior reimbursements will be available to you at all times during the Plan Year. You will be reimbursed the entire amount of your claim, if it is less than your Annual Contribution Election.

(b) **Expense must be eligible for reimbursement under this plan:** The expense must qualify as medical care within the meaning of the Plan for reimbursement from the Medical FSA. Please refer to https://learn.hellofurther.com/ for a list of eligible expenses.

(c) **Expense must have been incurred during your period of coverage for plan year:** You may only use your Medical FSA to pay for Medical Expenses that you incurred during the Plan Year and Grace Period following the Plan Year. Expenses incurred during one Plan Year cannot be reimbursed from contributions in another Plan Year, except that expenses incurred during a Grace Period can be reimbursed from Grace Period Amounts from the prior Plan Year. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter. The only exception is that expenses may be treated as incurred for orthodontia services before the services are provided if the orthodontist (following his or her normal practice) requires you to make advance payments to receive the services (*e.g.*, requires you to pay a lump sum for services to be provided that year and the next).

(d) **Expense cannot be reimbursed out of other accounts:** Amounts contributed to the Medical FSA cannot be used to reimburse expenses from the Dependent Care FSA and vice versa.

(e) **Claim submission requirements must be satisfied.** You may submit a completed claim form and independent third-party documentation of the claim to the Administrator. You may also submit your claim Online by signing into the Member Online Service Center via www.HelloFurther.com. If your Company implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Medical FSA Plan, some expenses may be validated at the time the expense is incurred (like copays for medical care). For other expenses, the card payment is only conditional. You will still have to submit supporting documents. You will receive more information from the Company about what you must do to obtain reimbursement if such a system is implemented.

1. *Claims must be submitted during the Plan's Claims Submission Period.* **Further must receive all claims for reimbursement in our office no later than 12 months after the plan year end date to be reimbursed.**

For employees that have terminated during the plan year and they have not elected COBRA (if available) claims must be received in our office 3 months from the termination date.

For employees that have terminated during the plan year and have elected COBRA (if available) claims must be received in our office 12 months from the plan year end. Upon termination of COBRA, claims must be received in office 3 months from the termination date.

2. *Documentation must be provided.* To receive reimbursement for an Eligible Expense, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill or receipt) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is incomplete, the claim may be denied and payment delayed.

3. *Claims cannot be reimbursed by Health Insurance.* You cannot submit claims for reimbursement if you have already been reimbursed by health insurance or if you intend to request reimbursement.

(f) **Method of reimbursement:** To the extent the Claims Administrator determines that a claim is properly payable under the Plan; you will be reimbursed for the expense either through a check or via direct deposit, if you have selected that option. Reimbursements will be issued as scheduled by the Claims Administrator.

(g) **Recovery of improper reimbursements:** You will be required to repay the Plan for reimbursements determined by the Claims Administrator to be ineligible for reimbursement under the Plan or otherwise improper. The Claims Administrator may use one or more of the following recovery methods: (i) you repay the amount to your Medical FSA or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount

from future reimbursement payments to you for Eligible Medical Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement will be treated as a business debt and the amount reimbursed will be included in your W-2 income.

CLAIMS AND APPEAL PROCEDURE

(a) **Initial determination on claim for reimbursement**

1. *Time Period.* Within 30 days after receipt of a claim, the Claims Administrator will make its decision on the claim. The 30-day period for the initial review determination by the Plan Administrator may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Plan; and (ii) the Administrator provides notice of the extension to you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Plan expects to render its decision. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.

2. *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notification of the denial to you which will include the specific reason for the denial, a reference to the Plan provision on which the denial is based, a description of additional information or documents necessary in order for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure. If a denial is based on an internal rule or guideline or medical judgment, information regarding the internal rule or guideline or medical judgment will either be included in the written response or you will be able to obtain a copy of the internal rule or guideline or an explanation of the medical judgment on request and free of charge.

(b) **Appeal rights and procedures.**

1. *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Plan Administrator. You must send a written request for an appeal review to the Plan Administrator within 180 days of your receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.

2. *Right to Review Documents/Submit Comments.* You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Plan administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.

3. *Person Conducting Review.* The review will be conducted by a named fiduciary for the Plan who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination. In deciding an appeal of any adverse benefit determination that is based, in whole or in part, on a medical judgment, the administrator will consult with a medical care professional who has appropriate training and experience in the applicable medical field and who is neither the individual who was consulted in connection with the initial adverse determination nor a subordinate of such individual.

4. *Notice of Continued Denial.* If the denial is upheld in whole or part, the Claims Administrator will send notification of the denial to you. You will be notified of the Claims Administrator's decision on appeal in writing within 60 days after receipt of your appeal; this includes both levels of appeals. The notice will include the Claims Administrator's reason for its decision.

    i. *Level Two Appeal Process.* Following the Level One Appeal Process, you have additional voluntary appeal rights through Further. If you are not satisfied with our decision, you may elect to further appeal to Further by sending a letter within 30 days or the later of your run out end date requesting our Appeals Committee to reconsider the decision. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or our customer service department. You have the option to present your concerns to the Appeals Committee either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.

    ii. You may elect this voluntary appeal (Level Two Appeal) only after you have submitted a Level One Appeal and that appeal has been denied. You are not required to submit a Level Two Appeal prior to bringing a claim in court (the plan will not assert that you failed to exhaust administrative remedies in not submitting to a Level Two Appeal). The six-month limitation period

provided in the Plan Document within which you may bring a claim to court is tolled during the time that the Level Two Appeal is pending.

GRACE PERIOD AND FORFEITURE OF ACCOUNT BALANCE

(a) **Grace Period:** You will now have an additional 9999 months in the following Plan Year in which you can incur Eligible Expenses that may be reimbursed from your Account balance from the previous Plan Year. The Grace Period claims need to be submitted by the end of the Claims Submission Period.

(b) **Forfeiture:** According to federal tax law, amounts remaining in your Medical FSA over $0 after the end of the Claims Submission Period following payment of Eligible Expenses incurred during the Plan Year and any Grace Period must be forfeited. Such forfeited amounts will be used by the Plan Administrator, in its discretion, to pay the cost of benefits under the Plan, for administrative costs of the Plan, or to provide additional benefits to participants. Planning carefully on the amount to contribute to the spending accounts should help you to avoid forfeitures. Refer to our website at https://learn.hellofurther.com/ for a Medical FSA Election Worksheet to help you determine your contribution.

TERMINATION OF PARTICIPATION DUE TO TERMINATION OF EMPLOYMENT

(a) **When participation ends:** If your employment with the Company terminates, your participation in the Plan will end as of the date of your termination of employment.

(b) **Medical expenses incurred after termination:** Medical expenses incurred after the date of your termination from employment will not be eligible for reimbursement unless you elect to continue your participation in the Medical FSA. Please refer to the COBRA continuation information in the "Notice" section below.

(c) **Amounts remaining after termination:** Any amounts remaining in an account after the end of the Claims Submission Period for the Plan Year in which the termination occurred will be forfeited.

(d) **Re-employment by a Participating Employer:** If you terminate employment and are re-employed by a participating employer, you may participate in the Plan. Whether you are required to resume your elections in place prior to your termination or may make new elections depends on the length of time between your termination and reemployment and whether you are reemployed in the same Plan Year or a new Plan Year.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class within 30 days and within the same Plan Year will be required to resume participation in the Plan and the participant's prior benefit elections will be reinstated.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class after 30 days or more and within the same Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class in a new Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

OTHER REASONS FOR TERMINATION OF PARTICIPATION

(a) Your participation in this Plan can also end if:

1. you no longer qualify as an Eligible Employee;

2. your Employer stops participating in this Plan;

3. you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan;

4. the Company terminates the Plan; or

5. if the certifications you made to participate are no longer accurate

(b) The rules discussed above for termination of participation as a result of termination of employment also apply if termination of participation occurs for other reasons.

NOTICES

(a) **COBRA Continuation of Medical FSA Coverage:** You, your spouse or any of your dependents who lose coverage under the Medical FSA as a result of a "qualifying event" are “qualified beneficiaries” and will be eligible to continue Medical FSA coverage for the remainder of the current Plan Year as indicated in this section.

1. *Medical FSA Positive Balance Requirement.* To be eligible for COBRA: (i) there must be a positive balance in your Medical FSA as of the date your coverage would otherwise terminate because of a qualifying event; and (ii) the COBRA Premiums you are required to pay for the remainder of the Plan Year must exceed available reimbursements.

2. *Qualifying Events.* For employees, the qualifying events are: (i) termination of employment for any reason other than gross misconduct; and (ii) a reduction in hours. For a spouse or dependent, the qualifying events may include: (i) the employee's termination of employment for any reason other than gross misconduct; (ii) the employee's loss of eligibility for coverage due to a reduction in scheduled work hours; (iii) the employee's death; (iv) the employee's divorce or

legal separation; (v) a dependent child's ceasing to qualify as an eligible dependent under the Medical FSA; and (vi) the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

3. *Maximum COBRA Coverage Period.* COBRA continuation coverage is a temporary continuation of Medical FSA coverage. For each qualified beneficiary who elects COBRA continuation coverage, the COBRA coverage will begin on the date of the qualifying event. The maximum COBRA coverage period is through the end of the Plan Year in which the qualifying event occurred and any Grace Period following such Plan Year. The continuation coverage period is a maximum period that will be reduced as described below.

4. *You must provide notice to the Plan Administrator of certain events.* The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or the employee's death, the employer will notify the Plan Administrator of the Qualifying Event. Qualified beneficiaries must notify the Plan Administrator of the employee's divorce, legal separation or child's ceasing to qualify as a dependent under the Medical FSA within 60 days of the date of the qualifying event. If the Plan Administrator is not given the notice within 60 days, the right to continue coverage will be lost.

5. The notice must be in writing, must contain the information described below, and must be mailed by first class mail, postage prepaid and addressed to the Plan Administrator at the address indicated in the **Plan Specifications** section of this summary.

6. The notice must contain the following information: (i) the name, address and Social Security Number of the employee; (ii) the name, address and Social Security Number of each qualified beneficiary (*e.g.*, employee, spouse, dependent child); (iii) a description of the qualifying event; (iv) the date of the qualifying event; and (v) a list of the Benefit Options under which the affected qualified beneficiaries are covered.

7. *Type of Coverage available for Continuation***.** A qualified beneficiary may elect to continue the Medical FSA coverage in effect immediately before the qualifying event.

8. *Who may elect COBRA Coverage?* An employee can make the election for himself or herself, his or her spouse, or any of his or her dependent children. If the employee does not make the election, his or her spouse can make the election for himself or herself and any dependent children. Finally, if neither the employee nor spouse makes the election for a dependent child, the dependent may make the election for him or herself. (A child who is born to, or placed for adoption with,

the employee while the employee is continuing coverage under COBRA and who becomes covered by the Medical FSA will have independent COBRA election rights as if he or she were covered at the time of the qualifying event.)

9. *COBRA Election Period.* After a qualifying event or receiving notice of a qualifying event (if notice is required), the Plan Administrator will send qualified beneficiaries a notice regarding COBRA election rights. Qualified beneficiaries will have 60 days from the date of such notice (or from the date coverage would otherwise terminate because of the qualifying event, if the coverage would stop after the notice is sent) in which to file a written election to continue coverage. If a qualified beneficiary does not file the election within the 60-day period, he or she will lose the right to continue Medical FSA coverage. The election must be filed with the Plan Administrator at the address specified in the election form.

10. *COBRA Contributions.* Contributions for the continuation coverage will be on an after-tax basis unless your Compensation continues and the Plan Administrator permits pre-tax contributions for continuation coverage. A qualified beneficiary must pay the full contribution, plus a 2% administration fee, for any coverage he or she continues. He or she must make the first contribution payment, covering the period between the date coverage would otherwise stop and the end of the month preceding the date of the payment, within 45 days after the date the election to continue coverage was filed. Subsequent contributions are due on the first day of each month for which a qualified beneficiary continues coverage, and coverage will end if he or she fails to pay the contribution for any month within 30 days after the due date.

11. *No COBRA Coverage Pending Election or Payment.* A qualified beneficiary will not have COBRA coverage until he or she has elected the coverage and made the required contribution payment. No claims for health care incurred while coverage is not in effect will be eligible for reimbursement. Once a qualified beneficiary makes the election and pays the contribution, coverage will be reinstated retroactively to the date he or she lost the coverage.

12. *Termination of COBRA Coverage.* The continuation coverage will terminate when the first of the following events occurs: (i) the end of the current Plan Year; (ii) the qualified beneficiary fails to pay the initial contribution within 45 days after your election, in which case he or she will be treated as not having elected to continue Medical FSA coverage; (iii) the qualified beneficiary fails to pay any other contribution within 30 days after it is due, in which case coverage will end as of the end of the last day of the month for which he or she made a timely contribution payment; (iv) after electing continuation coverage, the qualified beneficiary becomes entitled to any other group health plan that does not limit or exclude coverage because of a preexisting condition (coverage already in place at the time of the continuation coverage election will not cause termination of

continuation coverage); and (v) the employer ceases to provide Medical FSA account benefits to any of its employees.

13. *Keep the Plan informed of Address Changes.* To protect Medical FSA COBRA continuation rights, qualified beneficiaries should keep the Plan Administrator informed of any address changes.

14. *Keep Copies of Notices.* Qualified beneficiaries should also keep copies for their records of any notices sent to the Plan Administrator.

15. *Plan Administrator Contact Information.* The address and telephone number for the Plan Administrator is listed in the **Plan Specifications** section of this summary.

(b) **HIPAA Privacy Rule Notice of Privacy Practices:** The Medical FSA component of the Plan is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the Plan's *Notice of Privacy Practices* (which summarizes the Plan's Privacy Rule obligations, your Privacy Rule rights, and how the Plan may use or disclose health information protected by the Privacy Rule) from the Plan Administrator.

(c) **Statement of ERISA Rights of Plan Participants:** As a Participant in the 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:

1. *Receive Information about your Plan and Benefits.*

   i. Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

   ii. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 series) and the latest updated summary plan description. This *Summary*, along with the Plan Document for the HRA, comprise the Plan Document for this benefit. The Plan Administrator may make a reasonable charge for the copies.

   iii. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

2. *Continue Group Health Plan Coverage.* Continue health care coverage 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 Summary for your HRA COBRA continuation rights.

3. *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 this Plan. The people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit provided under this Plan or exercising your rights under ERISA.

4. *Enforce your Rights.* If your claim for a 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 you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. 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.

5. *Assistance with your Questions***.** If you have any questions about this 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 (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, 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.

(d) **Company's right to terminate or amend the Plan:** The Company reserves the right to amend or terminate the Plan at any time and without notice.

(e) **No guarantee of employment:** Participation in this Plan is not a guarantee of employment.

(f) **Plan Administrator's discretion:** The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

PLAN SPECIFICATIONS

Employer, Plan Sponsor and Plan Administrator:

CSM CORPORATION
500 Washington Ave S Ste 3000
Minneapolis, MN 55415

Telephone: 612-395-7050

Claims Administrator:

Further
3535 Blue Cross Road
Eagan, MN 55122-1154
651-662-5065 or 800-859-2144
www.HelloFurther.com

Plan Year:

January 1 through December 31

CSM CORPORATION

Flexible Spending Plan

Dependent Care FSA Summary

INTRODUCTION

CSM CORPORATION's Flexible Benefit Plan (the "Plan") permits Eligible Employees to choose to pay for certain benefits on a pre-tax basis.

This *Summary* describes the Dependent Care Flexible Spending Account ("Dependent Care FSA") Benefit Option under the Plan. Terms may be defined in this *Summary* and in the *Plan Document*.

Through the Dependent Care FSA, you can pay Dependent Care Expenses on a pre-tax basis. This will generally result in a tax savings and increase your spendable income.

Refer to our *DCAP Essential Guide* for a tax savings example. You may also want to use the *Tax Savings Calculator* link available at https://learn.hellofurther.com/ to estimate your tax savings.

The tax benefit you experience will depend on the benefits you elect, as well as other factors that affect the amount of taxes you pay. Although participating in the Plan can provide significant tax advantages, there may be tax disadvantages to participating in the Plan based on your particular situation. You may wish to consult with your tax advisor.

DETAILS OF THE DEPENDENT CARE FSA BENEFIT

(a) **Dependent care Expenses Eligible for reimbursement:** You can use your Dependent Care FSA to pay for Dependent Care Expenses. Dependent Care Expenses must be work-related to be eligible for reimbursement. Details are provided below. Examples of Eligible Dependent Care Expenses are at https://learn.hellofurther.com/. **Your minimum annual contribution is $100 per plan year. The maximum annual contribution for this benefit is the maximum allowed by the IRS. Note that salary reduction amounts from the last paycheck of the Plan Year may be used to pay for the first month of benefits elected for the next Plan Year.**

1. "Dependent Care Expense" means:

   i. an amount that you incur for the Care of a Qualifying Individual and Household Services incidental to that care

   ii. to enable you, and if you are married, your spouse to be "gainfully employed" or to actively search for "gainful employment" (*i.e.*, the dependent care must be necessary for you to work or to find work)

2. A Dependent Care Expense is "incurred" on the date on which the services are provided, regardless of the date on which payment for such services is due or made.

3. "Qualifying Individual" is defined below.

4. "Care of a Qualifying Individual" means services, the primary purpose of which is to provide for the Qualifying Individual's well-being and protection. It does not include the provision of food, clothing or education unless such benefits are incidental to such primary purpose and does not include the provision of education to an individual in kindergarten or any higher grade.

5. "Household Services" are services performed in and around your home that are ordinary and usual services necessary to maintain your household and are attributable, at least in part, to the Care of the Qualifying Individual.

6. "Gainfully employed" or "gainful employment" means a job. Your spouse will be deemed to be gainfully employed during any month in which he or she is either a full-time student at an educational institution or is a Qualifying Individual (*i.e.*, physically or mentally incapable of caring for himself or herself).

(b) **You must request reimbursement:** To receive reimbursement for Dependent Care Expenses, you must submit a completed claim form (which includes your promise that the expenses have not been reimbursed from any other source and that you will not seek reimbursement for the expenses from any other source) and independent third-party documentation of the expense.

Online: To receive reimbursement for FSA expenses, you may submit your form by signing into the Member Online Service Center via www.HelloFurther.com and submitting your claim online.

(c) **Maximum benefits:** Federal law limits the amount that can be reimbursed from your Dependent Care FSA if you are married but file a separate federal income tax return and if you are single or married filing a joint federal income tax return. Moreover, benefits can never be more than your "earned income" for the year. Your earned income is your adjusted gross income or, if less, the adjusted gross income of your spouse if you are married. If your spouse is unemployed because he or she is incapable of self-care or is a full-time student, your spouse will be deemed to have an earned income of a certain amount per month depending upon whether there is one Qualifying Individual or two or more Qualifying Individuals. IRS Publication 503, which you may obtain from the IRS's web site at http://www.irs.gov describes the deemed earned income limitation.

Note: If the Plan provides a Grace Period, Carryover Amounts used to pay Eligible Expenses incurred during the Grace Period will count toward the $5,000 maximum for the calendar year in which such expenses are paid. Refer to the *Plan Specifications* section to determine whether the Plan provides a Grace Period.

(d) **Dependent Care tax credit:** The federal tax law allows you to take a tax credit on your federal income tax return for qualified dependent care expenses in an amount up to $3,000 for one dependent and up to $6,000 for two or more dependents. (Your potential tax credit is a percentage of these amounts that depends on your adjusted gross income).

The difference between the Dependent Care FSA and the tax credit is that the Dependent Care FSA provides a reduction in your taxable income, while the tax credit offers a direct reduction on the amount of tax you pay. You cannot use the Dependent Care FSA and the tax credit for the same expenses. In addition, use of the Dependent Care FSA will reduce dollar for dollar or eliminate your tax credit. You will need to determine which of these methods is best for you, because each person's tax situation is unique, your own tax advisor should be consulted to help you determine which approach is best for you. The Dependent Care Tax Savings Worksheet in our *DCAP Essential Guide* may be helpful in determining whether the tax credit is more advantageous for you.

(e) **Reimbursements are reported on form W-2:** The reimbursements you receive for Dependent Care Expenses will be reported to the IRS on your W-2 Form for the year. These amounts should not generally be taxable unless: (i) your reimbursements exceed your earnings for the year or, if you are married on the last day of the year, your spouse's earnings for the year; or (ii) you do not report the taxpayer identification number of your dependent care service provider when you file your federal income tax return.

(f) **Dependent Care provider information on tax return:** You will be required to list on your annual tax return the names and taxpayer identification numbers of any persons who provided you with dependent/day care services during the calendar year for which you have claimed a tax-free reimbursement.

(g) **Expenses cannot be reimbursed from any other source, including tax credits or tax deductions:** Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud and you personally will be responsible for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.

ELIGIBLE EMPLOYEES

Only eligible employees may participate. You are eligible if you are:

- Employed by the company or a participating employer
- Regularly scheduled to work 30 or more hours per week
- Are not an excluded individual
- Satisfy any other eligibility requirements

You are a participant if you are an eligible employee, have enrolled in the Dependent Care FSA Plan, and have not terminated participation.

Eligible employees do not include:

- Leased employees

- Independent contractors
- Employees subject to a collective bargaining agreement (except as specifically provided in the collective bargaining agreement)
- Interns
- Employees classified as temporary
- Employees covered by written agreements stating they are not eligible to participate in this Plan.

DEPENDENTS

(a) You may only use the Dependent Care FSA to be reimbursed for expenses of someone who qualifies as your Dependent.

(b) For the Dependent Care FSA, "Dependent" means someone who meets the requirements of a "Qualifying Individual." If a Dependent ceases to meet these requirements during a Plan Year (e.g., a dependent child turns 13), Eligible Dependent Care Expenses incurred before the Dependent ceased to meet the requirements may still be reimbursed.

(c) A Qualifying Individual means an individual who is your Qualifying Child, Qualifying Spouse or Qualifying Relative, as defined below

If you and your child's other parent do not live together, only the parent with primary physical custody (parent with whom the child resides for more than six months out of the year) can be reimbursed for Dependent Care Expenses for the child and then only for the days in which the child resides with him or her. The other parent cannot seek reimbursement of Dependent Care Expenses even for the days during which the child resides with him or her.

1. *A Qualifying Child*. This means an individual who:

   i. has one of the following relationships to you: son, daughter, stepdaughter, stepson, brother, sister, stepbrother, stepsister, foster child, or child for whom the you have legal guardianship (or a descendent of any of these individuals);

   ii. is under the age of 13;

   iii. lives with you for more than one half the year; and

   iv. does not provide more than one half of his or her own support.

2. *A Qualifying Spouse*. This means your spouse who:

i. lives with you for more than half of the year; and

ii. is physically or mentally incapable of self-care.

3. *A Qualifying Relative*. This means an individual:

i. who has a "Qualifying Child" relationship to you (as specified in subsection (c)(1)(i) above) or who is your father, mother, stepfather, stepmother, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law, or who lives with you and is a member of your household;

ii. who is not your Qualifying Child or the Qualifying Child of any other person;

iii. for whom over one half of whose support for the year is provided by you;

iv. who lives with you more than half of the year; and

v. who is physically or mentally incapable of self-care.

ENROLLMENT AND PARTICIPATION

(a) **Initial Enrollment:** You must enroll within 30 days of becoming an Eligible Employee. An eligible employee may participate in the Plan on the first of the month following 60 days of employment. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement.

(b) **Annual Open Enrollment:** If you do not enroll when you are first eligible, you must wait until the next Open Enrollment Period for another chance to participate (unless you experience an "Election Change Event" and make a "Qualifying Election Change," as discussed later in this *Summary*). Federal tax law prohibits any other mid-year enrollment. The Open Enrollment Period for each Plan Year will be determined by the Plan Administrator.

(c) **Enrollment procedure:** The Plan Administrator will provide enrollment instructions. You must complete your enrollment within the time specified by the Plan Administrator.

(d) **Dependent Care FSA election:** You must indicate the amount you want to contribute, if any, to a Dependent Care FSA when you enroll.

(e) **Mid-Year Enrollment:** You must enroll within 30 days after becoming an Eligible Employee. Employees are eligible for this benefit on the first of the month following 60 days of employment, at which time participation will begin. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement.

ELECTION CHANGES DURING THE PLAN YEAR

(a) **Qualifying Election Changes:** Your election for any Plan Year cannot be changed during the Plan Year unless you experience an Election Change Event and make an election change that is on account of and consistent with the event (called a "Qualifying Election Change"). For complete details, request a copy of the Plan Document from the Plan Administrator or contact the Claims Administrator for assistance.

(b) **Examples.**

1. If you add a child to your family (through birth or adoption), you can increase your Dependent Care FSA election.

2. If a child or other Dependent is no longer a Qualifying Individual (for example, your child turns 13), you may decrease or terminate your Dependent Care FSA election.

3. If you divorce and your child no longer lives with you, you may decrease or terminate your Dependent Care FSA election.

4. If your cost for dependent care changes, you may make a corresponding change to your Dependent Care FSA election (unless your Dependent Care provider is a relative).

5. If your need for dependent care changes due to a job change or a change in work hours, you may make a corresponding change to your Dependent Care FSA election.

(c) **You cannot elect an amount less than the amount already reimbursed:** An election change will not be consistent with an Election Change Event if the new amount elected is less than the amount already reimbursed from the Dependent Care FSA for the Plan Year.

(d) **Time limit for making election change:** To change your election, you must request an election change not later than 30 days after the Election Change Event (even if you are on leave at the time). You cannot change your election more than 30 days after an Election Change Event.

(e) **Election change process:** The Plan Administrator will provide instructions for requesting an election change. The Plan Administrator will determine whether an election change is permitted.

PARTICIPATION DURING A LEAVE OF ABSENCE

General rules. Coverage will continue under this Plan during a leave of absence in accordance with the Company's leave policies and the terms and conditions of the Plan. If there is a conflict between the information provided in this section and the Company's leave policies, the Company's leave policies will control. Your leave must be approved by the Company.

You will be required to make your premium/contribution payments ("payment" or "payments") for coverage to continue. If you do not make the required payment when due (including any grace period), the Company may retroactively terminate your coverage to the last day for which you have paid. Expenses incurred during the period for which your coverage is retroactively terminated will not be covered. The Company can recover any payments owed. Upon return to work, any payments owed will be taken from your pay. Contact the Plan Administrator for coverage payment options.

Additional Rules for Dependent Care FSAs

(a) **Paid Leave of Absence:** Your Dependent Care FSA contributions will automatically continue as long as you continue to receive pay. Although you will continue to contribute to your Dependent Care FSA during a paid leave, dependent care expenses you incur during the leave will not be eligible for reimbursement due to tax rules. Do not submit claims for reimbursement for dependent care expenses incurred during your leave.

(b) **Unpaid Leave of Absence:** Your Dependent Care FSA contributions will terminate during an unpaid leave. Dependent care expenses you incur during an unpaid leave will not be eligible for reimbursement. You may reinstate your Dependent Care FSA contributions on return from leave.

(c) **Open Enrollment during your Leave:** If the open enrollment period for the next Plan Year occurs during your leave and your participation in the Plan continues, you will be able to make elections for Plan benefits for the new Plan Year in the same manner as active employees. If you do not elect Dependent Care FSA benefits, you will not be eligible to participate in these benefits in the new Plan Year, unless you experience an Election Change Event and make an election change within 30 days of that event.

(d) **Making Election Changes on return from Leave:** Election changes other than as noted in this section will not be permitted on return from leave unless you experience another Election Change Event and make the election change within 30 days of the event.

PART-TIME EMPLOYMENT AND ABSENCES FROM WORK FOR MINOR ILLNESS OR VACATION

(a) **Part-Time Employment:** Only Dependent Care Expenses incurred on the days during the week that both you and your spouse are working are eligible for reimbursement. If you and/or your spouse work part-time but are required to pay for dependent care on a weekly or monthly basis for both days worked and not worked (part-time daycare is not available), the entire cost will be eligible for reimbursement.

(b) **Temporary-Absences due to minor illness or vacation:** Only Dependent Care Expenses incurred on the days during the week that both you and your spouse are working are eligible for reimbursement. Dependent Care Expenses incurred while you and/or your spouse are absent from work for a few days due to a minor illness or vacation, however,

are still eligible for reimbursement if you are required to pay for dependent care on a weekly or monthly basis for both days worked and not worked. An absence of no more than two consecutive weeks is considered a temporary absence.

OBTAINING REIMBURSEMENTS

(a) **Amount available for reimbursement:** The amount available for reimbursement during the Plan Year will be limited to the balance in your Dependent Care FSA (your payroll contributions, less any reimbursements already made from the Account for that Plan Year).

(b) **Expense must be eligible for reimbursement under this Plan:** The expense must qualify as a Dependent Care Expense within the meaning of the Plan for reimbursement from the Dependent Care FSA. Please refer to https://learn.hellofurther.com/ for a list of eligible expenses.

(c) **Expense must have been incurred during your period of coverage for Plan Year:** You may only use your Dependent Care FSA to pay for Dependent Care Expenses that you incurred during the Plan Year and Grace Period following the Plan Year. Expenses incurred during one Plan Year cannot be reimbursed from contributions made during another Plan Year, except that expenses incurred during a Grace Period can be reimbursed from Grace Period Amounts from the prior Plan Year. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter.

(d) **Expense cannot be reimbursed out of other accounts:** Amounts contributed to the Dependent Care FSA cannot be used to reimburse expenses from the Medical FSA and vice versa.

(e) **Claim submission requirements must be satisfied.** You may submit a completed claim form and independent third-party documentation of the claim to the Administrator. You may also submit your claim Online by signing into the Member Online Service Center via www.HelloFurther.com

1. *Claims must be submitted during the Plan's Claims Submission Period.* **Further must receive all claims for reimbursement in our office no later than 12 months after the plan year end date to be reimbursed.**

   For employees that have terminated during the plan year, claims must be received 3 months from the plan year end.

2. *Documentation must be provided.* To receive reimbursement for an Eligible Expense, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill or receipt) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is

incomplete, the claim may be denied and payment delayed.

(f) **Method of reimbursement:** To the extent the Claims Administrator determines that a claim is properly payable under the Plan; you will be reimbursed for the expense, either through a check or via direct deposit, if you have selected that option. Reimbursements will be issued as scheduled by the Claims Administrator. Your claim for a Dependent Care Expense will be paid up to the amount you have contributed to your Dependent Care FSA as of the day the claim is processed. If the claim amounts exceed the amount in your account, you will be reimbursed up to the amount available in your account. A claim balance will be carried forward and will be paid when additional funds become available. You do not need to send in more than one claim for an Eligible Expense.

(g) **Recovery of improper reimbursements:** You will be required to repay the Plan for reimbursements determined by the Claims Administrator to be ineligible for reimbursement under the Plan or otherwise improper. The Claims Administrator may use one or more of the following recovery methods: (i) you repay the amount to your Dependent Care FSA or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount from future reimbursement payments to you for Eligible Dependent Care Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement may be treated as a business debt and the amount reimbursed will be included in your W-2 income.

CLAIMS AND APPEAL PROCEDURE

(a) **Initial determination on claim for reimbursement**

1. *Time Period.* Within 30 days after receipt of a claim, the Claims Administrator will make its decision on the claim. The 30-day period for the initial review determination by the Claims Administrator may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Plan; and (ii) the Administrator provides notice of the extension to you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Plan expects to render its decision. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.

2. *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notification of the denial to you which will include the specific reason for the denial, a reference to the Plan provision on which the

denial is based, a description of additional information or documents necessary in order for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure.

(b) **Appeal Rights and Procedures.**

1. *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Claims Administrator. You must send a written request for an appeal review to the Claims Administrator within 180 days of your receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.

2. *Right to Review Documents/Submit Comments.* You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Claims Administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.

3. *Person Conducting Review.* The review will be conducted by a person who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination.

4. *Notice of Continued Denial.* If the denial is upheld in whole or part, the Claims Administrator will send notification of the denial to you. You will be notified of the Claims Administrator's decision on appeal in writing within 60 days after receipt of your appeal, this includes both levels of appeals. The notice will include the Claims Administrator's reason for its decision.

    i. *Level Two Appeal Process.* Following the Level One Appeal Process, you have additional voluntary appeal rights through Further. If you are not satisfied with our decision, you may elect to further appeal to Further by sending a letter within 30 days or the later of your run out end date requesting our Appeals Committee to reconsider the decision. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or our customer service department. You have the option to present your concerns to the Appeals Committee either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.

ii. You may elect this voluntary appeal (Level Two Appeal) only after you have submitted a Level One Appeal and that appeal has been denied. You are not required to submit a Level Two Appeal prior to bringing a claim in court (the plan will not assert that you failed to exhaust administrative remedies in not submitting to a Level Two Appeal). The six-month limitation period provided in the Plan Document within which you may bring a claim to court is tolled during the time that the Level Two Appeal is pending.

GRACE PERIOD AND FORFEITURE OF ACCOUNT BALANCE

(a) **Grace Period:** You will now have an additional 9999 months in the following Plan Year in which you can incur Eligible Expenses that may be reimbursed from your Account balance from the previous Plan Year. The Grace Period claims need to be submitted by the end of the Claims Submission Period. Any amounts remaining in your Accounts following the Grace Period (and after the end of the Claims Submission Period) will be forfeited.

(b) **Forfeiture:** According to federal tax law, amounts remaining in your Dependent Care FSA after the end of the Claims Submission Period following payment of Eligible Expenses incurred during the Plan Year and any Grace Period must be forfeited. Such forfeited amounts will be used by the Plan Administrator, in its discretion, to pay the cost of benefits under the Plan, for administrative costs of the Plan, or to provide additional benefits to participants. Planning carefully on the amount to contribute to the spending accounts should help you to avoid forfeitures. Refer to our https://learn.hellofurther.com/ for a Dependent Care FSA Election Worksheet to help you determine your contribution.

TERMINATION OF PARTICIPATION DUE TO TERMINATION OF EMPLOYMENT

(a) **When Participation ends:** If your employment with the Company terminates, your participation in the Plan will end as of the date of your termination of employment.

(b) **Dependent Care Expenses incurred after termination:** If you have a balance remaining in your Dependent Care FSA after your termination from employment, your participation in this benefit will be deemed to continue until you have "spent down" your Account or through the end of the Plan Year in which your termination occurred, whichever occurs first. You can submit Dependent Care Expenses incurred after the date of your termination but before the end of that Plan Year. All other Plan requirements for eligibility of Dependent Care Expenses, including that the expenses must be necessary for you to work or to find work, must be satisfied.

(c) **Amounts remaining after Termination:** Any amounts remaining in an account after the end of the Claims Submission Period for the Plan Year in which the termination occurred will be forfeited.

(d) **Re-employment by a Participating Employer:** If you terminate employment and are re-employed by a participating employer, you may participate in the Plan. Whether you are

required to resume your elections in place prior to your termination or may make new elections depends on the length of time between your termination and reemployment and whether you are reemployed in the same Plan Year or a new Plan Year.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class within 30 days and within the same Plan Year will be required to resume participation in the Plan and the participant's prior benefit elections will be reinstated.

A Participant who terminates employment and is re-employed by a participating employer in an eligible employee class after 30 days or more and within the same Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

A Participant who terminates employment and is re-employed by a participating employer in an eligible employee class in a new Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

OTHER REASONS FOR TERMINATION OF PARTICIPATION

(a) Your participation in this Plan can also end if:

1. you no longer qualify as an Eligible Employee;

2. your Employer stops participating in this Plan;

3. you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan; or

4. the Company terminates the Plan.

(b) The rules discussed above for termination of participation as a result of termination of employment also apply if termination of participation occurs for other reasons.

NOTICES

(a) **ERISA, HIPAA and COBRA do not apply:** The Dependent Care FSA is not an employee benefit plan within the meaning of ERISA and is not subject to ERISA, HIPAA or COBRA.

(b) **Company's right to terminate or amend the Plan:** The Company reserves the right to amend or terminate the Plan at any time and without notice.

(c) **No guarantee of employment:** Participation in this Plan is not a guarantee of employment.

(d) **Plan Administrator's discretion:** The Plan Administrator (and persons to whom it has

delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

PLAN SPECIFICATIONS

Employer, Plan Sponsor and Plan Administrator:

CSM CORPORATION
500 Washington Ave S Ste 3000
Minneapolis, MN 55415

Telephone: 612-395-7050

Claims Administrator:

Further
3535 Blue Cross Road
Eagan, MN 55122-1154
651-662-5065 or 800-859-2144
www.HelloFurther.com

Plan Year:

January 1 through December 31