Summary Plan Description for the Inovalon, Inc. Employee Benefit Plan for Flexible Spending Accounts

- Health Care Flexible Spending Accounts
- Dependent Care Reimbursement Plan
- Parking/Transit Reimbursement Plan

Effective Date: January 1, 2020

Introduction

Inovalon, Inc. (the "Employer" or "Company") is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet describes your flexible spending accounts and serves as the Summary Plan Description (SPD) for the Inovalon, Inc. Health and Welfare Plan for Flexible Spending Accounts ("the Plan").

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. It is written to comply with disclosure requirements under the Employee Retirement Income Security Act ("ERISA") of 1974, as amended.

The Plan is intended to meet the requirements of Code Section 125 and the Treasury Regulations thereunder. The Health Care Flexible Spending Account is intended to qualify as a self-insured medical reimbursement plan under Code Section 105. The Dependent Care Flexible Spending Account is intended to qualify as a "dependent care assistance plan" under Code Section 129. Eligible expenses reimbursed are excluded from income in accordance with the applicable Code section above.

We encourage you to read this booklet and become familiar with your benefits.

This SPD replaces all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

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Plan Overview

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee normally scheduled to work a minimum of 30 hours per week;
- On the regular payroll of the Company; and
- In a class of employees eligible for coverage.

The following individuals are not eligible for benefits: part-time employees, employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

See IRS Publication 969 – Health Savings Accounts and Other Tax-Favored Health Plans for additional information.

For purposes of the Dependent Care Flexible Spending Account, your qualifying dependents are defined by Code Section 21(b)(1) of the Code and include:

- a child under age 13 in your custody whom you claim as a dependent on your Federal tax return;
- a spouse who in incapable of self-care; and
- a dependent who lives with you – such as a child over age 13, a parent, a sibling, or an in-law who is incapable of self-care, and whom you claim as a dependent on your Federal tax return.

Generally, to be claimed as a dependent on your Federal tax return, an individual must be dependent on you for more than one-half of his or her support (principally supported), as defined by Code Section 152 of the Internal Revenue Code.

Special rules apply for children of divorced/separated parents. The IRS has issued guidance for divorced/separated parents, or parents who live apart, to determine which parent may claim a Federal income tax exemption for a dependent child. You should consult your tax advisor if you have any questions concerning a dependent's status.

When Coverage Begins

You are eligible for coverage after you meet all eligibility requirements for the Employer's Health and Welfare Plan.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Company to deduct any salary reduction contributions from your pay.

The elections you make will remain in effect until the next Plan Year, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will have no coverage for the remainder of the plan year.

Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. You must make a new election each year to participate in the Flexible Spending Accounts. Current year elections will not automatically continue in the new Plan year. The elections you make will take effect on for following Plan Year, unless you have a qualifying change in status.

Effect of Tax Regulations on this Plan

This Plan is designed and administered in accordance with Sections 125 and 129 of the Internal Revenue Code and Section 132 for any Parking/Transit Plans, if applicable. These code sections enable you to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days of the date you have a qualifying change in status as described below.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you may change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by the Internal Revenue Service (IRS), status changes applicable may include:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation (if that affects eligibility);
- a change in a dependent child’s eligibility due to age or eligibility for other coverage;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a change in your Company work location or home address that changes your overall benefit options and/or prices;
- a significant change in coverage or the cost of coverage (not applicable for HCFSA);
- a reduction or loss of your or a dependent’s coverage under this or another plan;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child.

Additionally, your election(s) may be modified downward during the plan year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) if necessary to prevent the Plan from becoming discriminatory.

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. You should report a status change as soon as possible, but no later than 31 days after the event occurs.

When Coverage Ends

Your coverage under this Plan ends day of the month in which your employment terminates or you cease to be an eligible employee.

If your coverage under the Health Care Flexible Spending Account ends due to a COBRA qualifying event, you will be given the opportunity to continue your coverage the same coverage you had in effect the day before the qualifying event on a self-pay basis. However, you will be eligible for COBRA Continuation Coverage only if you have a positive Health Care Expense Account balance at the time of the COBRA qualifying event (taking into account all claims submitted by you before the date of the qualifying event). If COBRA is elected, it will be available only for the remainder of the Plan Year (and any extended period) in which the qualifying event occurs and coverage will cease at the end of the Plan Year. Coverage will not be continued for the next Plan Year.

Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, your coverage will be canceled and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Coverage may also be rescinded for failure to pay required premiums or contributions as required by the Plan.

Coverage may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you. You will receive 30 days advance written notice of any cancellation of coverage to be made on a prospective basis.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the premiums paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you.

Coverage While Not at Work

In certain situations, coverage may continue when you are not at work, so long as you continue to pay your required contributions to the Plan. You should discuss with your supervisor what options are available for remitting your Flexible Spending Account contributions while you are absent from work.

Your Flexible Spending Account Benefits

Your Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account

The Health Care Flexible Spending Account offers you a convenient way to pay for eligible, unreimbursed health care expenses using pre-tax dollars. You “fund” your account by directing a portion of your pay to your Flexible Spending Account.

Health Care Expense Account

If you elect to participate in the Health Care Flexible Spending Account, a Health Care Expense Account will be established for you. This account will be maintained for bookkeeping purposes only to keep track of contributions and reimbursements, and to determine forfeitures. It will not be funded.

Your Health Care Expense Account will be credited with the amount you authorize to be deducted from your pay and debited with any amount reimbursed to you for allowable medical care expenses.

Maximum Annual Amount

The maximum annual benefit amount that you may elect under the Health Care Flexible Spending Account for a Plan Year is $2,750 and a minimum of $130.

The Plan Administrator has discretion to change the maximum and/or minimum contributions in subsequent years.

Eligible Medical Expenses

The Health Care Flexible Spending Account will pay only claims incurred during the year that are for eligible “Medical Expenses”, as that term is defined in Code Section 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. Expenses may be submitted for you, your spouse, and your “qualified dependents”, as such term is defined in Internal Revenue Code Section 152.

The following expenses do not qualify for reimbursement:

- any expense you claim as an itemized deduction on your Federal income tax return;
- premium payments for other health care coverage, including COBRA premiums;
- weight loss programs or dietary supplements;
- hair replacement treatments;
- over-the-counter drugs or medicines unless the purchase was obtained by prescription;
- cosmetic surgery or dentistry procedures, unless related to a congenital abnormality, a personal injury resulting from accident or trauma, or a disfiguring disease; or
- any expense determined to be ineligible as determined by the Plan Administrator.

For a list of eligible expenses, contact the Claims Administrator. Allowable Medical Expenses may also be found in IRS Publication 502 Medical and Dental Expenses or on the IRS Web site at www.irs.gov.

Payment of Health Care Expense Account Claims

The maximum amount available to you for reimbursement will be the lesser of:

- The amount of allowable medical expenses submitted for reimbursement; or
- The total annual Salary Reduction Contribution you elected for the year, less any prior reimbursements.

The Plan will reimburse only those allowable medical expenses which have been incurred by you and/or your dependents that are in excess of any payments or other reimbursements made under any other health care plan. Advance reimbursement will not be made for projected or future expenses.

If you are participating in the Health Care Flexible Spending Account on the last day of the Plan Year and you have an unused amount remaining in your FSA, up to $500 may be carried forward to be used in the following Plan Year. Carry forward amounts from the previous plan year may:

- reduce your amount available to pay previous plan year expenses during the run-out period,
- will be counted against the permitted carryover amount, and
- cannot exceed the carryover amount.

Continuation Coverage Upon Termination

If your coverage in the Health Care Flexible Spending Account terminates due to a COBRA qualifying event, you will be given the opportunity to continue (on a self-pay basis) the same coverage you had in effect the day before the qualifying event prescribed by COBRA. However, you will be eligible for COBRA Continuation Coverage only if you have a positive Health Care Expense Account balance at the time of the COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). If COBRA is elected, it will be available only for the remainder of the year in which the qualifying event occurs and will cease at the end of that year. Your Health Care Flexible Spending Account coverage cannot be continued for the next year.

Qualified Reservist Distribution

In accordance with the “Heroes Earning Assistance and Relief Tax Act of 2008” (“HEART Act”), a qualified reservist distribution (QRD) is permitted for all or part of any unused Health Care FSA amounts if you are a reservist called to active duty provided that:

- You are called up for a period of 180 days or more or for an indefinite period of time; and
- The request for a distribution is made during the period of time between when the order or call is made and the last day that a reimbursement could be made from the Health Care FSA for that plan year.

To receive a QRD of all or part of any unused Health Care FSA amounts, you must give notice by contacting the Plan Administrator as soon as you receive your orders or are called to active duty. For additional information on how to request a qualified distribution, contact the Claims Administrator.

Your Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account offers you a convenient way to pay for eligible, unreimbursed day care expenses for your eligible dependents using pre-tax dollars. You "fund" your account by directing a portion of your pay to your Flexible Spending Account.

Dependent Care Expense Account

If you elect to participate in the Dependent Care Flexible Spending Account, a Dependent Care Expense Account will be established for you. This account will be maintained for bookkeeping purposes only to keep track of contributions and reimbursements, and to determine forfeitures. It will not be funded.

The Dependent Care Expense Account will be credited with the amount you authorize to be deducted from your pay each pay period and debited with amounts reimbursed to you for eligible dependent care expenses.

Maximum/Minimum Annual Amount

The maximum annual benefit amount that you may elect under the Dependent Care Flexible Spending Account for a calendar year is the smallest of the following amounts: 1) $5,000 ($2,500 if you are married and filed your Federal tax return as Married – Filing Separately); or 2) the lesser of the calendar year earned income limitation for you or your spouse described in Section 129(b) of the Code. If your spouse is not employed and is either 1) physically or mentally incapable of self-care; or 2) a student during a month in which you incur a dependent care expense, Earned Income shall be the amount specified in Code Section 21(d)(2). There is a minimum election of $130.

The Plan Administrator has discretion to change the maximum and/or minimum contributions in subsequent years.

Eligible Dependent Care Expenses

You may use the Dependent Care FSA to pay certain dependent care expenses that are necessary to allow you – and your spouse, if you are married – to work or attend school full-time. The Plan will reimburse all employment-related expenses defined by Section 21(b)(2) of the Code, incurred by you on behalf of a qualifying dependent. These include payments to babysitters or companions inside or outside the home, licensed day care centers, as well as Federal and state taxes which you pay for providers of dependent care. For purposes of this Section, a qualifying dependent will be defined by Section 21(b)(1) of the Internal Revenue Code.

Reimbursement will be made upon your submission of documentation that such expenses were incurred to enable you to be gainfully employed for any period during which there was one or more qualifying dependents, provided however that:

- If such amounts are paid for expenses incurred outside your household, they shall constitute employment-related expenses only if incurred for a qualifying dependent under Section 21(b) of the code, who regularly spends at least 8 hours per day in your household;
- If the expense is incurred outside your home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at the

facility, the facility must comply with all state and local laws and regulations, including licensing requirements, if any; and

- Employment-related expenses for you do not include amounts paid or incurred to your child over the age of 19 or to an individual who is a dependent of you or your spouse.

NOTE: **The Family Support Act of 1988 requires that you provide the name, address, and taxpayer identification number (or Social Security number) of your provider. You must include this information when you submit a claim for reimbursement.**

The following expenses do not qualify for reimbursement:

- Transportation expenses to or from the day care center;
- Care provided by an individual who could be claimed as a dependent on your or your spouse's Federal tax return;
- Services which are eligible for reimbursement under any other plan or program;
- Clothing, education, or food, unless food and education are provided by the day care center or nursery school as part of its prescribed care services. Food and education expenses are not covered for kindergarten or higher;
- Tuition;
- Overnight camp expenses;
- Expenses for days when you are not working (such as sick or vacation days) or any other day when you do not meet the eligibility requirements.

A complete list of allowable dependent care expenses can be found in IRS Publication 503 Child and Dependent Care Expenses or on the IRS Web site at www.irs.gov.

If you have questions about what is considered an eligible expense under the Dependent Care Flexible Spending Account, contact the Claims Administrator.

Payment of Dependent Care Expense Account Claims

The maximum amount available for reimbursement at any time from a Dependent Care Expense Account shall be the lesser of:

- The amount of allowable dependent care expenses submitted for reimbursement; or
- The amount credited to the Participant's Dependent Care Expense Account at that time, reduced by previous reimbursements during the year.

Your Dependent Care Expense Account will be reduced by the amount of the reimbursement paid. Advance reimbursement shall not be made for projected or future expenses.

Dependent Care Expense Account Annual Statement of Benefits

On or before January 31 of each calendar year, as required by applicable law and regulations, the Plan Administrator will provide you with a summary of all Dependent Care Expense Account benefits paid to you during the previous calendar year. This amount is typically shown on your Form W-2.

Child Care Tax Credit

The IRS allows you to claim work-related dependent care expenses for credit on your Federal income tax return. The tax credit is determined by applying a percentage to your total

work-related dependent care expenses. You may use both a dependent care flexible spending account and the tax credit, provided you do not claim the same expenses for both. You must also adjust your tax credit by the amount you contribute to the Dependent Care Flexible Spending Account. For more information about the child care tax credit, see IRS Publication 503 or IRS Form 2441 and the accompanying instructions. You may also wish to consult with your tax advisor to determine which option is best for your particular tax situation.

Your Debit Card

When you enroll in a Flexible Spending Account, you will automatically receive a debit card for use in paying for eligible expenses directly from your Expense Account, in some cases, without having to file a claim form. However, dependent care expenses may not be reimbursed before the expenses are incurred. If your provider requires payment before dependent care services are provided, the expenses cannot be paid using the debit card.

When you receive your card, read the terms and conditions found on the card insert, then sign the back of your card. If you choose to activate your card, you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will then be ready to use.

Your card may be used at any approved provider or merchant with a point-of-service (POS) bankcard terminal. Examples of qualified locations and providers include: hospitals, physician and dental offices, vision care providers, retail pharmacies, as well as many child and adult day care facilities.

Using Your Debit Card

In order to use your card, follow the instructions included with your card. It can be used at any POS bankcard terminal, just as if you were purchasing an item using a credit card. Your Flexible Spending Account and debit card are regulated by the IRS, therefore it is your responsibility to retain all itemized receipts. If a payment must be verified, the Plan Administrator also may request this receipt from you to ensure that payment was made for a qualified expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

A transaction that includes non-eligible items or services will be denied completely, even though a portion of the transaction may be eligible. If you are purchasing non-eligible expenses at a location, you will need to purchase these items in a separate transaction.

Your card can be used for co-payments, deductibles, and coinsurance at many physician locations. However, the card does not determine any patient responsibility or eligible benefits.

When you use your card at a POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your Expense Account based on the guidelines established by the IRS and the terms of the Plan.

For questions about using your card, or to report a lost or stolen card or request additional cards, contact the Claims Administrator.

Submitting a Claim for Reimbursement

You may submit a claim form to the Claims Administrator to request reimbursement of incurred expenses. The Claims Administrator may utilize forms and require documentation of costs or other evidence as may be necessary to verify the claims submitted. All claims must include the name of the person on whose behalf the claim has been incurred, the nature and date of the incurred expense, a statement that the expense has not otherwise been reimbursed, and such other information required to process the claim, such as bills, invoices, or other similar documentation.

Expenses are incurred at the time the service is received, not when the care or service is billed, charged, or paid. All claims for reimbursement will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized. Reimbursement payments shall be payable to you.

If an expense is determined to not be an “eligible expense” you will receive notification of this determination. If you are denied a benefit under the Heath Care FSA or Dependent Care FSA, you may file an appeal as explained below under “Claims and Appeals Procedure”.

The Claims Administrator will provide a summary with each reimbursement that shows the amount reimbursed and your current balance. You can also request information about your account balance by contacting the Claims Administrator.

Claims Submission and Cut-Off

The Plan Administrator will establish and communicate to all participants the cut-off date by which all claims for the year must be submitted. Claims submitted after that date will not be eligible for reimbursement and will be forfeited.

Rollover

After processing all claims for a Plan Year, and for each subsequent plan year, Health Care Flexible Spending Account plan participants will have the ability to roll-over up to $500 of unused Health Care Flexible Spending Account funds to the next Health Care Flexible Spending Account plan year.

Parking and Transit

This qualified transportation benefit, under IRC § 132 (f) permits employers to sponsor a program under which employees can pay on a pre-tax, salary reduction basis for qualified parking and transportation, up to certain monthly limits. By paying for those expenses on a salary reduction, pre-tax basis, employees receive tax savings.
The maximum monthly benefit amount that you may elect $270.

Overview of Benefits Under the Program - Who Is Eligible?
All active, regular, full-time employees, working at least 30 hours per week

Qualified Transportation & Parking
Qualified Transportation includes transportation in a commuter highway vehicle (with a seating capacity of at least 6 adults, exclusive of the driver, provided that 80% of its annual mileage is for transporting employees between their residence and their place of employment), transit passes (any pass, token, farecard, voucher or similar item that entitles a person to transportation on mass transit facilities (public); if issued for a private transit business-subject to the commuter vehicle requirement described above) and qualified

parking ((a) on or near the employer's business (including locations where an employee is required to perform services for the employer) or (b) at a location from which the employee commutes to work).

Limitations as determined by IRS guidelines and adjusted as the guidelines are adjusted.
There are separate limits (and accounts) for qualified parking and qualified transportation.

Changing your Pre-Tax Election
Should you wish to make any changes to your TRIP allocation, all changes must be made by the 10th of the month prior to the month you would like the new allocation (or revocation) to take effect.

Allocations
Funds allocated to TRIP cannot be paid back to the participant. They may only be used for reimbursement for qualified transportation and parking.

Claims Submission and Cut-Off
Claims must be submitted within 180 days of the expense. The Plan Administrator will establish and communicate to all participants the cut-off date by which all claims for the year must be submitted. Claims submitted after that date will not be eligible for reimbursement and will be forfeited

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

Plan Sponsor and Administrator

Inovalon, Inc. is the Plan Sponsor for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Inovalon, Inc.
4321 Collington Rd
Bowie, MD 20716
301-809-4000

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the "Named Fiduciary" for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Company. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;

- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Company, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year

The Plan Year is January 1 – December 31

Type of Plan

This Plan is called a “welfare plan”, which includes group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 71-1017974 PLAN NUMBER: 510

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The Company fully funds the cost of the Plan. Benefits will be paid solely from the general assets of the Company.

Claims Administrators

The Plan Administrator has contracted with the following company(ies) to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly, using the information listed below.

AP Benefit Advisors, LLC

FSA Claims Administrator
200 International Circle
Suite 4500
Hunt Valley, MD 21030
800-657-6265
Fsa.apbenefitadvisors.com

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

Inovalon, Inc.
4321 Collington Rd
Bowie, MD 20716
301-809-4000

Service of legal process also can be made upon the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Company to continue your employment or interfere with the Company's right to terminate your employment, with or without cause.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits

All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the covered participant, unless otherwise assigned.

Payment of Benefits to Others

The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud

No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the Company, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Company will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Non-discrimination

The Health Care Flexible Spending Account shall not discriminate in favor of "highly compensated individuals" as to eligibility to participate or benefits available. The Health Care Flexible Spending Account shall be operated consistently with Code Section 105(h), regulations promulgated thereunder, and guidance issued by the Department of Labor or the Internal Revenue Service relating to discrimination testing.

The Dependent Care Flexible Spending Account shall not discriminate in favor of "highly compensated employees" or more than 5 percent owners of a company. The Dependent Care Flexible Spending Account shall be operated consistently with Code Section 129, regulations promulgated thereunder, and guidance issued by the Department of Labor or the Internal Revenue Service relating to discrimination testing.

Future of the Plan

The Company expects that the Plan will continue indefinitely. However, the Company has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Company may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims and Appeal Procedure

This section describes what you must do to file or appeal a claim for services.

Time Frames for Processing Health-Related Claims

Health-related claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims with different time frames applicable to each. For purposes of the Health Care FSA, claims are treated as post-service health claims.

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

Once you have received your notice from the Claims Administrator, review it carefully. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If you disagree with this decision, you or your representative may file a written appeal for review of a denied claim with the Claims Administrator within 180 days after receipt of a notice of denial.

You will have the right to submit for review, written comments, documents, records, and other information related to the claim as well as any additional information you believe would support your claims. You also have the right to request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.

If after such review the Claims Administrator continues to deny the validity of the claim in full or in part, you may file a 2nd level appeal with the Plan Administrator. This appeal must be filed within 60 days of the first level appeal denial notice from the Claims Administrator. You should include any information necessary to perfect your claim and any other information that you believe supports your claim.

You will be notified of the Plan Administrator’s decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement regarding your right to bring civil action in Federal court under Section 502(a) of ERISA.

Each level of appeal will be independent from the previous level (i.e., the same persons involved in a prior level of appeal would not be involved in the next level). On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.

The final decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Time Frames for Processing All Other Claims

For all non-health related claims, you may file a claim with the Claims Administrator. The Claims Administrator will notify you of its decision in writing within 90 days after the claim is received.

Special circumstances may require an extension of this period up to 180 days for non-disability claims, but if an extension is required, you will be notified of any extension within the initial 90-day period. If an extension is necessary because you failed to submit necessary information, the days from the date the Claims Administrator sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

If your claim is denied, you will receive in writing the specific reasons that your claim was denied, the specific reference to the Plan provision(s) on which the denial was based, a description of any additional material or information necessary for you to perfect the claim and why such material or information is necessary, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, internal rules, guidelines, protocol, records and information relevant to your claim, and information regarding the Plan's appeal procedures and time frames, including what steps you need to take to appeal your claim.

To appeal a denied claim, you or your representative must send a written request for review to the Plan Administrator within 60 days after the denial is received. You should state the reason why you believe your claim should be reviewed and submit for review any written comments, documents, records, or other information that is relevant to your claim.

The Plan Administrator will conduct a review and make a final decision within 60 days after receipt of your request for review (or within 120 days if special circumstances warrant an extension, provided you are notified of the extension within the initial 60-day period).

You will be notified of the Plan Administrator's decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement regarding your right to bring civil action in Federal court under Section 502(a) of ERISA.

The final decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit in Federal court, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. You cannot take any other steps or file any other claims or suits for benefits unless and until you have exhausted all administrative appeals.

Your Rights under ERISA

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 will be entitled to the following.

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free-of-charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request the certificate before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit 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 previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it 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 administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or 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 also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator(s) and/or Insurer(s) a separate “Notice of Privacy Practices” which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to medical and prescription drug plans, including Health Care Flexible Spending Accounts. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual’s physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- coordination of benefits; and
- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Claims Administrator involved with the PHI in question. The Claims Administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan sponsor or any Business Associate of the Plan sponsor becomes aware.

Continuing Your Health Care FSA through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

If your coverage under the Health Care Flexible Spending Account ends due to a COBRA qualifying event, you will be given the opportunity to continue the same coverage you had in effect the day before the qualifying event on a self-pay basis.

COBRA Continuation Coverage will be available to you only if you have a positive Health Care Expense Account balance at the time of the COBRA qualifying event (taking into account all claims submitted by you before the date of the qualifying event). If COBRA is elected, it will be available only for the remainder of the Plan Year (and any extended period) in which the qualifying event occurs and coverage will cease at the end of the Plan Year. Coverage will not be continued for the next Plan Year.

COBRA Notifications

If you lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

Cost of COBRA Coverage

You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus any required administrative fee up to two percent, or up to 102 percent of the full premium cost, except in the case of an 11-month disability extension where you may be required to pay up to 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full payment is received. Each month's premium is due prior to the first day of the month of coverage. You are responsible for making timely payments.

If you fail to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

Definitions

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

Employee

A person who works for the Company in an employer-employee relationship.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Company for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Company has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Company. You should contact the Company with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

HIPAA

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

Participant

An eligible employee who elects to participate in the Plan by completing the necessary enrollment forms.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A Federal law covering the rights of participants who have a qualified uniformed services leave.