SALARY REDUCTION PLAN (CAFETERIA PLAN) SUMMARY PLAN DESCRIPTION

PREMIUM PAYMENT BENEFITS/HEALTH FSA/HSA

Overhead Door Corporation (the "Employer") is pleased to sponsor an employee benefit program known as the Salary Reduction Plan ("Plan") for you and your fellow employees. The Plan is called a cafeteria plan because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to pay for selected benefits by entering into a salary reduction agreement by which you elect to pay for the benefits on a pre-tax basis instead of receiving a corresponding amount of your regular pay. This arrangement helps you because the benefits that you elect are non-taxable and you save Social Security and income taxes on the amount of your salary reduction.

This Summary Plan Description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. This is only a summary of the key parts of the Plan and a brief description of your rights as a Participant. It is not part of the official Plan documents and if there is a conflict between the Plan documents and this Summary Plan Description, the Plan documents will control.

General Information About the Salary Reduction Plan

Plan Name:	Salary Reduction Plan
Type of Plan:	Organized under Section 125 of the Internal Revenue Code to allow Plan participants to pay for various qualified benefits on a pre-tax basis, including medical care expenses reimbursed under the Health FSA component intended to qualify as a "self-insured medical reimbursement plan" under Section 105 of the Internal Revenue Code, and contributions to a Health Savings Account under Section 223 of the Internal Revenue Code. Health Savings Accounts are not subject to ERISA.
Plan Year:	January- December; records are kept on a plan year basis
Effective Date:	This current plan is effective as of January 1, 2023
Funding Medium:	Benefits are paid through Employee salary reductions and by Employer, contributions from the Employer's general assets.
Source of Contributions:	Benefits are paid through both Employer and Employee contributions.
Plan Sponsor:	Overhead Door Corporation 2501 S. State Hwy 121 Bus. Suite 200 Lewisville, TX 75067 (469) 549-7100
Plan Sponsor's EIN:	35-0564120

Plan Administrator:	Overhead Door Corporation 2501 S. State Hwy 121 Bus. Suite 200 Lewisville, TX 75067 (469) 549-7100
Named Fiduciary:	Overhead Door Corporation 2501 S. State Hwy 121 Bus. Suite 200 Lewisville, TX 75067 (469) 549-7100
HSA Trustee/Custodian	BenefitWallet P.O. Box 1584 Secaucus, NJ 07094
Administrative Assistance for Health FSA:	The Plan Administrator has contracted with the following company to assist it in providing administrative assistance for the Health FSA: HealthEquity/WageWorks 15 W. Scenic Pointe Drive, Ste. 100 Draper, UT 84020
Agent for Service of Legal Process:	Vice President, Compensation & Benefits Overhead Door Corporation 2501 S. State Hwy 121 Bus. Suite 200 Lewisville, TX 75067 (469) 549-7100
Related Employers Adopting Plan:	Door Services Corporation 2501 S. State Hwy 121 Bus. Suite 200 Lewisville, TX 75067 (469) 549-7100 EIN: 27-4267438 GMI Holdings, Inc. 2501 S. State Hwy 121 Bus. Suite 200 Lewisville, TX 75067 (469) 549-7100 EIN: 31-1302102 Won-Door Corporation 1865 South 3480 West Salt Lake City, UT 84104 (801) 973-7500 EIN: 87-0262989

Legal Plan Document & Disclaimer:	This Summary Plan Description summarizes the principal features of the Plan in a general manner. The terms and conditions of the Salary Reduction Plan are contained in the legal document adopted by the Employer. If the provisions of this Summary conflict with those of the Plan, the provisions of the legal Plan document will control. You can obtain a copy of the legal Plan document from the Plan Administrator.

Q-1 What is the purpose of the Plan?

The purpose of the Plan is to allow eligible Employees to use funds provided through employee salary reductions to pay for benefits under the Plan with pre-tax dollars.

Q-2 What benefits are provided by the Plan?

The Plan includes the following types of benefits:

(a) Premium Payment Benefits: permits Employees to elect coverage for certain insurance benefits made available through the Employer provided the Employee meets the eligibility requirements of the applicable insurance policy or benefit plan.

(b) Health Flexible Spending Account ("Health FSA"): permits an Employee to pay for his or her qualifying Medical Care Expenses (defined in Q-22) that are not otherwise reimbursable by insurance with pre-tax dollars. Benefits provided under the Health FSA are called "Health FSA Benefits."

(c) Health Savings Account ("HSA")- permits an Employee to make pre-tax contributions to an HSA established and maintained outside of the Plan with the Employee's HSA trustee/custodian. Benefits provided under the HSA are called "HSA Benefits."

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

Q-3 Who can participate in the Plan?

Only Employees can participate in the Plan. In addition, Employees must be full-time as defined by the Employer and are then eligible on the first day of the month following or concurrent with 60 days of employment.

Eligibility for HSA Benefits also requires you to be an "HSA-Eligible Individual" as discussed in Q-40.

Those Employees who actually participate in the Plan are called "Participants." An Employee continues to participate until (a) the end of the Plan Year for which the election to participate was made, unless the Participant elects during the Annual Enrollment Period (defined in Q-6) to continue participation; (b) the termination of the Plan; (c) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction in hours, or for

any other reason), except that eligibility may continue beyond such date for purposes of pre-taxing COBRA coverage as may be permitted by the Administrator on a uniform and consistent basis (but not beyond the current Plan Year); or (d) the Participant revokes his or her election, as described in Q-7.

Q-4 What tax savings would I gain by participating in the Plan?

You save both federal income tax and FICA (Social Security) taxes by participating in the Plan. The following is an example of the tax savings you might experience as a result of participating in the Plan on a pre-tax basis.

Suppose that you are married and have one child, your spouse earns no income, and you file a joint tax return. Suppose also that your annual gross pay is $75,000, and your share of the annual premiums for benefits that you have elected is $2,400. If you pay your premiums on a pre-tax basis, you would only be taxed on $72,600 of income as opposed to $75,000.

Q-5 How do I become a Participant?

After you complete the eligibility requirements described in Q-3 you become a Participant by signing an individual Election Form/Salary Reduction Agreement on which you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits so elected. You must complete the Election Form/Salary Reduction Agreement and turn it in to the Plan Administrator within the time period specified by the Administrator of the Plan in the enrollment materials. Also, the Election Form/Salary Reduction Agreement will be made available to you during the Annual Enrollment Period, and you will be given the opportunity during Annual Enrollment to elect your coverage for the next 12 months beginning on the first day of the Plan Year.

Q-6 What is the Annual Enrollment Period?

You will be notified of the duration of the Annual Enrollment Period. The Annual Enrollment Period for a Plan Year usually occurs during the last quarter of the previous Plan Year.

Q-7 Can I change my election for benefits or salary reduction during the Plan Year?

With the exception of amounts elected for your HSA, you generally cannot change your election to participate in the Plan or vary the salary reduction amounts you have selected during the Plan Year, except that your election will terminate if you are no longer eligible under this Plan (see Q-8).

There are several important exceptions to this irrevocability rule, known as Change in Election Events. "Change in Election Events" include the following events:

(a) Leaves of Absence. You may change an election under the Plan upon FMLA or non-FMLA leave as described in Q-14.

(b) Change in Status. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Administrator,

in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:

(i) a change in your legal marital status (such as marriage, death of Spouse, divorce, legal separation, or annulment). "Spouse" means the person who is legally married to you and is treated as a spouse under the Internal Revenue Code ("Code");

(ii) a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). "Dependent" means a "Dependent" as defined by the applicable benefit plan;

(iii) any of the following events that change the employment status of you, your Spouse or your Dependent and that affects benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of you, your Spouse or your Dependent. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from a salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or ceases to be) eligible for a particular employee benefit;

(iv) an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, student status or similar circumstance); and

(v) a change in your, your Spouse's or your Dependent's place of residence (note, however, this change in status does not apply to the Health FSA).

If you wish to change your election based upon a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility. Election changes may be made to reduce or increase Health FSA coverage during a Plan Year due to the occurrence of any of the following events: marriage; death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; gaining a Dependent; change in your employment status or the employment status of your Spouse or Dependent; or your Dependent's ceasing to satisfy eligibility requirements on account of attaining a certain age, etc.

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

(i) Loss of Spouse or Dependent Eligibility/Special COBRA Rules: For accident and health benefits (for example the Medical Benefits and the Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or

legal separation from your Spouse, the death of your Spouse or your Dependent , or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment or legal separation, your deceased Spouse or Dependent or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status. However, if you, your Spouse or Dependent elect COBRA continuation coverage (as described in Q-12) under the Employer's plan for any reason other than divorce, annulment or legal separation, or your child's ceasing to be a Dependent and you remain a Participant under the terms of this Plan, you may be able to increase your contribution to pay for such coverage.

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

(c) Special Enrollment Rights. With respect to Premium Payment Benefits under this Plan, if you, your Spouse, or a Dependent is entitled to special enrollment rights under a group health plan as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in the health insurance plan because of medical coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (legal separation, divorce, death, termination of employment, reduction in hours or exhaustion of COBRA) you may be able to elect health insurance under the Plan for yourself and your eligible Dependents who lost such coverage, provided that you request enrollment within 31 days after the applicable event. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may also be able to enroll yourself, your Spouse and your newly-acquired Dependent, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. Also, if you or your Dependent loses coverage under Medicaid or the Children's Health Insurance Program ("CHIP") as a result of loss of eligibility or if you or your Dependent become eligible for a premium assistance subsidy under Medicare or CHIP you are eligible to enroll mid-year provided you request enrollment within 60 days of the loss of coverage or entitlement to premium subsidies. Please refer to the summary plan description for the Health Benefit for an explanation of special enrollment rights.

(d) Certain Judgments, Decrees and Orders. With respect to Premium Payment Benefits and Health FSA Benefits, if a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under the Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child.

(e) Medicare or Medicaid. With respect to Premium Payment Benefits and Health FSA Benefits, if you, your Spouse or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's medical insurance under the Plan and/or your Health FSA coverage may be cancelled completely or reduced. Similarly, you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage, and/or begin or increase Health FSA coverage.

(f) Change in Cost. With respect to Premium Payment Benefits, if the Administrator notifies you that the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose to do any of the following: (i) make a corresponding increase in your contributions; (ii) revoke your election and receive coverage under another Plan option that provides similar coverage or elect similar coverage under the plan of your Spouse's employer; or (iii) drop your coverage, but only if there is no option available under the Plan that provides similar coverage. For insignificant increases or decreases in the cost of benefits, however, the Administrator will automatically adjust your election contributions to reflect the minor change in cost.

(g) Change in Coverage. With respect to Premium Payment Benefits, you may also change your election for the Plan if one of the following occurs:

(i) Significant Curtailment of Coverage. If the Administrator notifies you that your coverage under the Plan is significantly curtailed without a loss of coverage (for example, you hit the lifetime limits of the Plan), then you may revoke your election and elect coverage under another Plan option that provides similar coverage, if any. If the Administrator notifies you that your coverage under the Plan is significantly curtailed with a loss of coverage, then you may either revoke your election and elect coverage under another Plan option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage but only if there is no option available under the plan that provides similar coverage.

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

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

(iv) Change in Election Under Another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer) so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your Spouse during

his/her employer's annual enrollment to drop coverage, you may add coverage to replace the dropped coverage.

(h) For Major Medical Coverage only, certain reduction in hours or enrollment in coverage on the health insurance marketplace may allow you to prospectively revoke coverage as outlined in the Plan document.

In the event you experience a qualifying event listed above which allows you to increase or decrease your Health FSA, the amount available to you prior to the effective date of your election change will be the initial amount you elected for the Plan Year. The new amount available to you after the election change will be the total contributions paid up to the effective date of the election change plus the total contributions which will be paid for the remainder of the Plan Year minus the amount of any expenses already reimbursed. For example, if you elected $100 per month (or $1,200 per year) at the beginning of the Plan Year and change this election after three months to $200 per month (or $2,400 per year) without having submitted any expenses for reimbursement, the amount available to you after the election change and for the remainder of the Plan Year is $2,100 ($300 of contributions paid in the first three months, plus $1,800 contributions to be paid for the remainder of the Plan Year). Likewise, if you elected $200 per month (or $2,400 per year) at the beginning of the Plan Year and change this election after three months to $100 per month (or $1,200 per year) without having submitted any expenses for reimbursement, the amount available to you for the remainder of the Plan Year will be $1,500 ($600 of contributions already paid plus $900 in contributions for the remainder of the Plan Year). If, however, in either instance you had eligible expenses reimbursed prior to the election change, the amount available to you after the election change would be reduced by the amount of expenses already reimbursed for the Plan Year.

Additionally, the Administrator may modify your election(s) downward during the Plan Year if you are a key employee or highly compensated individual, if necessary to present the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-8 What happens if my employment ends during the Plan Year, or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. If you are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, your prior elections will be reinstated.

If you cease to be an eligible Employee for reasons other than termination of employment, such as a reduction in hours, you must complete the waiting period described in Q-3 before again becoming eligible to participate in the Plan.

Q-9 Will I pay any administrative costs under the Plan?

No. The cost is paid in part by the use of forfeitures, if any (see Q-26 and Q-37). The rest of the cost of administering the Plan is paid entirely by the Employer. A separate HSA trustee/custodial fee may be assessed by your HSA trustee/custodian.

Q-10 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate all or any part of the Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11 What happens if my claim for benefits is denied?

Premium Payment Benefit Claims. If your claim is for a benefit under any of the Premium Payment Benefits, you will generally proceed under the claims procedure applicable under that Plan, as described in the plan document or summary plan description for the applicable Premium Payment Benefit.

HSA Claims Not Involving Issues Relating to Salary Reductions. Claims relating in any way to the HSA established and maintained by you outside of the Plan with your HSA trustee/custodian (for example, issues involving investment or distribution of your HSA funds) shall be administered by your HSA trustee/custodian in accordance with the HSA trust or custodial document between you and such trustee/custodian.

Claims Under the Health FSA Component. However, if (a) a claim for reimbursement under the Health FSA Component of the Plan is wholly or partially denied, or (b) you are denied a benefit under the Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to your coverage under the Plan (for example, a determination of: a Change in Status; a "significant" change in premiums charged; or eligibility and participation matters under this Plan), then the claims procedure described below in this Q-11 will apply.

If your claim is denied in whole or in part, you will be notified by the Administrator within 30 days of the date the Administrator received your claim; provided however, this deadline may be extended by up to 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The decision will be in writing and will contain the following information:

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

Appeals by Participant. If your claim is denied in whole or part, you (or your authorized representative) may request review upon written application to the individual responsible for appeals designated on page 2 of this Summary Plan Description. Your appeal must be made in writing within 180 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim.

Decision on Review. Your appeal will be reviewed and decided by the individual or entity designated in the Plan in a reasonable time not later than 60 days after your request for review is received. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your claim (the identify of a medical expert consulted in connection with your appeal will be provided). If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

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

Q-12 What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your Spouse's and Dependents' right, to continue the same coverage under any component medical benefit plan (such as the Medical Insurance Plan and the Health FSA Benefits, among others) that was in place the day before a *Qualifying Event* if participation by you (including your Spouse and Dependents) otherwise would end due to the occurrence of such Qualifying Event. Continuation coverage under federal law is provided under COBRA (Consolidated Omnibus budget Reconciliation Act of 1985). Your Employer is subject to COBRA. Your COBRA rights and responsibilities are more fully set forth in the General COBRA Notice at the end of this Summary Plan Description.

Q-13 How will participating in the Plan affect my Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

Q-14 How do leaves of absence (such as under the FMLA) affect my benefits?

FMLA Leaves of Absence. If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, your Employer will continue to maintain your health, dental and vision benefits, if any, HSA Benefits, and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the premium to the extent you opt to continue coverage). Your Employer may elect to continue all health, dental and vision benefits, if any, and Health FSA Benefits coverage for Participants while they are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your

share of the premiums by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis if that is what was used before the FMLA leave began).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), and you opt to continue your health, dental and vision benefits, if any, and Health FSA Benefits, then the Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave.

If your Employer requires all Participants to continue health, dental and vision benefits and Health FSA Benefits during the unpaid FMLA leave, you may discontinue paying your share of the required premium until you return from leave. Upon returning from leave you must pay your share of any required premiums that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, as you and the Administrator may agree.

If your health, dental and vision benefits or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be entitled to re-enter such Benefits, as applicable, upon return from such leave on the same basis as you were participating in the Plan before the leave, or otherwise required by the FMLA. You are entitled to have coverage for such Benefits automatically reinstated so long as coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be entitled to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not pay premiums. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, your election for non-health benefits will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave. If that policy permits Participants to discontinue contributions while on leave, Participants will upon returning from leave be required to repay the premiums not paid by the Participant during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Administrator and the Participant or as the Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the premium due for you will be paid by pre-payment before going on leave, after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility, see Q-7.

Q-15 What are "Premium Payment Benefits"?

Under the Plan you can elect to participate in various benefit plans offered through the Employer. Currently, the Employer offers the following Premium Payment Benefits:

Major Medical
Dental

Vision
Group Term Life
AD&D

Q-16 How are my Premium Payment Benefits paid?

If you elect to participate in any of the Premium Payment Benefits described in Q-15, you may be required to pay a portion of the premiums for the Premium Payment Benefits that you have selected, as described in documents furnished separately to you. When you complete the Election Form/Salary Reduction Agreement, you specify that your share of the premiums will be paid with that portion of the gross income that you have elected to give up through pre-tax salary reductions. From then on, you must pay a premium for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally, an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Administrator).

Q-17 What are "Health FSA Benefits"?

If you elect Health FSA Benefits, you provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Under that Agreement, you agree to a salary reduction to fund Medical Care Expense instead of receiving a corresponding amount of your regular pay. This means that the premiums you pay will be paid with pre-tax funds. In return, you may be reimbursed from the Plan for certain eligible Medical Care Expenses . This arrangement helps you because the coverage you elect is nontaxable, which saves you Social Security and income taxes on the amount of your salary reduction.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and the Health FSA shall not be taken into account when determining benefits payable under any other plan.

Q-18 What is my "Health FSA Account"?

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

A Health FSA election may be for:

- General-Purpose Health FSA Coverage; or
- Limited (Vision/Dental/Preventative Care) Health FSA Coverage

Note, if you elect Health FSA Benefits, you cannot also elect HSA Benefits or otherwise make contributions to an HSA unless you elect the Limited (Vision/Dental/Preventative Care) Health FSA Coverage Option. If you are married and elect the General-Purpose Health FSA Coverage Option, your spouse will also be ineligible to make HSA contributions.

Q-19 What are the maximum and minimum Health FSA Benefits that I may elect?

You may choose any amount of Medical Care Expenses reimbursement that you desire under the Health FSA, subject to the maximum reimbursement amount allowable under the Code or as stated in the Election Form/Salary Reduction Agreement or other documentation provided to you, whichever amount is the least, per Plan Year. The current minimum contribution amount, if any, will be provided to you in the Election Form/Salary Reduction Agreement or other documentation. You will be required to pay the annual Health FSA "premium" equal to the coverage level you have chosen.

Q-20 How are my Health FSA Benefits paid?

When you complete the Election Form/Salary Reduction Agreement, you specify that your share of the costs will be paid through pre-tax salary reductions. From then on, you must pay a premium for such coverage by having that portion deducted from each paycheck (unless otherwise agreed with, or as deemed appropriate by the Administrator). The Employer may, but is not required, to make contributions to your Health FSA.

Q-21 What amounts will be available for Health FSA reimbursement at any particular time during the Plan year?

So long as you remain a Participant, the full amount of the coverage that you have elected (reduced by prior reimbursement made during the same Plan Year) will be available to reimburse you for eligible Medical Care Expenses incurred during the Plan Year plus any amounts properly carried over from the prior year (See Q-25), regardless of the amount of contributions that have been credited to your account. (See Q-7 regarding amounts available after election changes to increase or decrease your Health FSA.)

Q-22 What are "Medical Care Expenses"?

Your Health FSA election may be for the General Purpose Health FSA Coverage or Limited (Vision/Dental/Preventative Care) Health FSA Coverage. Each of these Health FSA coverage options is described in detail below. Note: You cannot elect HSA Benefits and Health FSA Benefits together unless you elect the Limited (Vision/Dental/Preventative Care) Health FSA Coverage Option. The eligible "Medical Care Expenses" vary according to the type of Health FSA coverage option that is elected as described below.

(a) General Purpose Health FSA Coverage Option. For purposes of the General-Purpose Health FSA Coverage Option, "Medical Care Expense" means expenses incurred by you, your Spouse or your Dependents for "medical care" as defined in Code § 213(d). Under the tax laws, "Medical Care Expenses" include expenses for prescription drugs, insulin, and over-the-counter drugs.

Be sure to ask the Administrator for help if you have any doubts about which expenses are--and are not--reimbursable.

(b) Limited (Vision/Dental/Preventative Care) Health FSA Coverage Option. According to rules set forth in Code § 223 (applicable to HSAs), you will not be able to make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses medical expenses as defined

for a General Purpose Health FSA in subsection (a) above. You may, however, be eligible to make/receive tax favored contributions to an HSA and participate in a Health FSA if the Health FSA reimbursement is limited to the following unreimbursed Code § 213(d) expenses:

- Services or treatments for dental care (excluding premiums);
- Services or treatments for vision care (excluding premiums; or
- Services or treatments for "preventative care" as defined by Code § 223(c)(2)(C).

Q-23. When are Medical Care Expenses incurred?

For Medical Care Expense to be reimbursed to you, they must have been incurred during the Plan Year. A Medical Care Expense is incurred when the service that gives rise to the expense is provided, not when the Expense was paid, provided, however, advance payments for orthodontia expenses are reimbursable when paid. Note that if you have paid for the expense but if the services have not yet been rendered, then the expense has not been incurred for this purpose. For example, if you pay for medical care on the first day of the month for care given on the 15th of that month, the expense has not been incurred until the 15th of that month. You may not be reimbursed for any expenses arising before the Plan became effective, before your Election Form/Salary Reduction Agreement became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service (except for Continuation Coverage, as described in Q-12).

Q-24 What must I do to be reimbursed for Medical Care Expenses?

There are two ways in which you may be reimbursed for Medical Care Expenses,. The Plan Administrator may provide a debit card which you can use to pay qualifying Medical Care Expenses. All other eligible expenses require you to submit a claim to the Administrator on a form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred, and the amount of such Medical Care Expenses along with the Flexible Spending Account Form. Generally, this requires including an Explanation of Benefits (EOB) Form from the medical insurance carrier (or a bill from a doctor's office) indicating the amounts that you are obligated to pay.

If you have paid the premiums for the Health FSA coverage you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Flexible Spending Account Form (subject to a 15-day extension for matters beyond the Administrator's control--see Q-11). Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount you have elected.

You will have until March 31 after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. You will be notified if any claims for benefits is denied. (See Q-11).

To have your claims processed as soon as possible, please read Q-11. Please note that it is *not* necessary for you to have actually paid the bill in an amount due for a Medical Care Expense--only for you to have *incurred* the expense (as defined in Q-23), and that it is not being paid for or reimbursed from any other source.

Q-25 What if the Medical Care Expenses I incur during the Plan Year are less than the annual amount that I elected for Health FSA Benefits?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Medical Care Expenses you have incurred and the annual coverage level you have elected and paid for. The difference will be forfeited as described in Q-26.

Q-26 When would I risk forfeiting my Health FSA Benefits?

You will forfeit any amount allocated to your Health FSA Account if that amount has not been applied to Health FSA Benefits for any Plan Year by March 31 following the end of the Plan year for which the election was effective. Amounts so forfeited shall be applied as described in the Plan (for example, used to offset Health FSA administrative expenses and future costs). Also, any Health FSA Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan year in which the Medical Care Expense was incurred shall be forfeited and applied as described in the Plan.

There is a limited exception for a Participant who is a member of a reserve component of the United States Armed Forces and is ordered or called to active duty for a period of 180 days or more or for an indefinite period of time. He/she may receive a refund of amounts contained in his or her Health FSA provided the request is made during the period beginning with the date of the order or call to active duty and ending on the last day of the then current Plan Year. For more information see the Plan Document or contact the Plan Administrator.

Q-27 Will I be taxed on the Health FSA Benefits I receive?

Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth in Q-19. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, you will be required to repay the amount. Ultimately, it is your responsibility to determine whether each payment to you under this Plan is excludable for tax purposes. You may wish to consult a tax advisor.

Q-28 What are "HSA Benefits"?

As described in Q-2, an HSA permits Employees to make pre-tax contributions to an HSA established and maintained outside the Plan with the Employee's HSA trustee/custodian. Additionally, the Employer may, but is not required, to make contributions to an Employee's HSA. As described in Q-1, if you elect HSA Benefits, then you will be able to provide a source of pre-tax contributions by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

To participate in the HSA Benefits you must be an "HSA-Eligible Individual." This means that you are eligible to contribute to an HSA under the requirements of Code § 223 and that you have elected qualifying High Deductible Health Plan coverage offered by the Employer and have not elected any

disqualifying non-high deductible health plan offered by your Employer. A "High Deductible Health Plan" means the high deductible health plan offered by your Employer that is intended to qualify as a high deductible health plan under Code § 223(c)(2) as described in materials that will be provided separately to you by the Employer. If you elect HSA Benefits, you will be required to certify that you meet all of the requirements under Code § 223 to be eligible to contribute to an HSA. These requirements include such things as not having any disqualifying coverage- and you should be aware that coverage under a Spouse's plan could make you ineligible to contribute to an HSA. In order to elect HSA Benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian.

If you elect Health FSA Benefits you cannot also elect HSA Benefits (or otherwise make contributions to an HSA) unless you elect the Limited (Vision/Dental/Preventative Care) Health FSA Coverage Option. For information on the impact of the Health FSA carryover option, see Q-18.

In the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, you may seek reimbursement from either but not both.

The HSA trustee/custodian will be chosen by you, as the Participant, and not by the Employer. Your Employer may, however, limit the number of HSA providers to whom it will forward pre-tax Salary Reductions, a list of whom will be provided upon request. Any such list of HSA trustees/custodians, however, shall be maintained for administrative simplification and shall not be an endorsement of any particular HSA trustee/custodian.

Q-29 What is my "HSA"?

The HSA is not an employer sponsored health benefit plan. It is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code § 223. Consequently, an HSA trustee/custodian, not the Employer, will establish and maintain your HSA. Your HSA is administered by your HSA trustee/custodian. Your Employer's role is limited to allowing you to contribute to your HSA on a pre-tax Salary Reduction basis. Your Employer has no authority or control over the funds deposited in your HSA. As such, the HSA identified above is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA").

The Plan Administrator will maintain records to keep track of HSA contributions that you make via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

Q-30 What are the maximum HSA Benefits that I may elect under the Salary Reduction Plan?

Your annual contribution for HSA Benefits is equal to the annual benefit amount that you elect. The amount you elect must not exceed the statutory maximum amount for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made. In addition, the maximum contribution shall be:

(a) reduced by a matching (or other) Employer contribution made on your behalf (there are currently no such Employer contributions (other than pre-tax Salary Reductions) made under the Plan); and

(b) pro-rated for the number of months in which you are an HSA-Eligible Individual.

Note that if you are an HSA Eligible Individual for only part of the year but you meet all of the requirements under Code § 223 to be eligible to contribute to an HSA on December 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (single or family). However, any contributions in excess of your annual contribution under the Plan for HSA benefits but not in excess of the applicable full statutory maximum amount, must be made outside the Plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of Code § 223 during the following year, the portion of HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a 10% penalty (exceptions apply in the event of death or disability).

Q-31 How are my HSA Benefits paid for under the Salary Reduction Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of HSA Benefits that you wish to pay for with your salary reduction. From then on, you make a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). Your Employer may, but is not required, to make contributions to your HSA. Your Employer will provide you with information on what amount, if any, it intends to contribute to your HSA. Your Employer, however, has no authority or control over the funds deposited in your HSA.

Q-32 Will I be taxed on the HSA Benefits that I receive?

You may save both federal income taxes and FICA (Social Security) taxes by participating in the Salary Reduction Plan. However, very different rules apply with respect to the taxability of HSA Benefits than for other Benefits offered under this Plan. For more information regarding the tax ramifications of participating in an HSA as well as the terms and conditions of your HSA see the communications materials provided by your HSA trustee/custodian and see IRS Publication 969.

Q-33 Who can contribute to an HSA under the Salary Reduction Plan?

Only Employees who are HSA Eligible Individuals can participate in the HSA Benefits. An HSA Eligible Individual means an individual who meets the eligibility requirements of Code § 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage. The terms of the High Deductible Health Plan that has been selected by your Employer will be further described in materials that will be provided separately to you by the Employer. Your Employer may, but is not required, to make contributions to your HSA. Your Employer will provide you with information on what amount, if any, it intends to contribute to your HSA.

Q-34 Can I change my HSA Contribution under the Salary Reduction Plan?

You may increase, decrease or revoke your HSA contribution election at any time during the plan year for any reason by submitting an election change form to the Plan Administrator (or to its designee). Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change. Your ability to make pre-tax

contributions under this Plan to the HSA identified above ends on the date that you cease to meet the eligibility requirements.

Q-35 Where can I get more information on my HSA and its related tax consequence?

For details concerning your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, high deductible health plans, contributions to the HSA, and distributions from the HSA) please refer to your HSA trust or custodial agreement and other documentation provided by your HSA trustee/custodian. You may also want to review IRS Publication 969.

Q-36 What are my ERISA Rights?

The Salary Reduction Plan is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act of 1974 ("ERISA"). However, the Health FSA Component is governed by ERISA. In addition, other Premium Payment Benefits may be governed by ERISA. For a description of your rights under ERISA with respect to a Premium Payment Benefit please see the applicable Summary Plan Description. The following are your rights under the Health FSA Component of this Plan:

Your Rights. Under the Health FSA Component, a participant has the right to:

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

(ii) Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) if any, and updated summary plan description.

(iii) Receive a summary of the Plan's annual financial report, if any. The Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

COBRA Rights. Under the Health FSA Component, you may have the right to continue coverage for the remainder of the Plan Year. Refer to Q-12 for a summary of your COBRA rights.

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

Enforce Your Rights. If your claim for a 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 from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the 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 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 (but only if you have first filed your claim under the plan's claim procedures, and if applicable, filed a timely appeal of any denial of your claim).

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

Assistance With Your Questions. If you have any questions about your plan, you should contact the Administrator. If you have any questions about this statement or your rights under ERISA or if you need assistance in obtaining documents from the 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Q-37 How will the Plan communicate with participants and beneficiaries?

The Plan communicates with you through the Plan Administrator. For your convenience and to improve efficiencies, the Plan Administrator will, to the extent allowable, communicate with you through electronic media, including providing claims information, notices and Plan documents through email and its website. If you do not have the ability to access electronic documents through your employment or accessing an electronic information system is not an integral part of your employment duties, you will be provided with paper documents unless you consent in writing to the receipt of electronic communications. If you have any questions regarding electronic communications or documents, please contact the Plan Administrator.

IMPORTANT NOTICE REGARDING
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under your Employer's Health Flexible Spending Account Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator.

COBRA Continuation Coverage

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

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

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

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

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes entitled to Medicare; or
(5) You become divorced or legally separated from your spouse.

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

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes entitled to Medicare;
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the plan as a "dependent child".

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's entitlement to Medicare; the employer must notify the Plan Administrator of the qualifying event within 31 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator, or its designee within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date coverage is lost due to the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, entitlement of the employee in Medicare, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months for the effected spouse and/or dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify the COBRA Administrator of that fact within 60 days of the later of the following events, but before the end of the 18 month period: (i) the SSA's determination; (ii) the date of the qualifying event; (iii) the date on which the qualified beneficiary would lose coverage under the plan; or (iv) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice through the plan's summary plan description or initial COBRA notice. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA Administrator of the fact within 30 days of SSA's determination. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any

required information or documentation.

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

If your family experiences another qualifying event that would have resulted in a loss of coverage under the Plan while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator, or its designee, is notified of the second qualifying event within 60 days of the second qualifying event. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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