

**Natural Gas Services Group, Inc. Cafeteria Plan**

**SUMMARY PLAN DESCRIPTION**

Effective April 1, 2009

# **Summary Plan Description**

## **With Premium Payment, Health FSA, and DCAP Components**

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**Natural Gas Services Group, Inc. Cafeteria Plan  
With Premium Payment, Health FSA, and DCAP Components**

**Summary Plan Description**

**Article I  
INTRODUCTION**

Natural Gas Services Group, Inc., (the "Employer") sponsors the Natural Gas Services Group, Inc. Cafeteria Plan (with Premium Payment, Health FSA, and DCAP Components) (the "Cafeteria Plan") that allows Eligible Employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pre-tax dollars. Alternatively, Eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

This Summary Plan Description (SPD) describes the basic features of the Cafeteria Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Cafeteria Plan and is not meant to interpret or change the provisions of your Plan. A copy of your Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. In the event of any inconsistencies or conflict between the actual provisions of the Cafeteria Plan document and this Summary, the Cafeteria Plan Document shall govern.

## **Article II PARTICIPATION IN YOUR PLAN**

### **How can I participate in the Cafeteria Plan?**

Once an Employee has met the Plan's eligibility requirements, and provided that the election procedures outlined under 'How do I become a Participant and when is my Entry Date?' section are followed, the Eligible Employee may participate in the Plan.

### **What are the Eligibility Requirements to participate in the Plan?**

Employees who have been employed by the Employer for 60 consecutive days, counting his or her Employment Commencement Date as the first such day and are employed by a participating Employer may participate in the Plan once they meet the eligibility requirements and provided that the election procedures outlined under 'How do I become a Participant?' section are followed.

Eligibility for the Premium Insurance Benefits is also subject to the additional eligibility requirements, if any, specified in the Medical Insurance Plan.

### **Are there any Employees who are not eligible to participate in the Plan?**

The following Employees are excluded from participating in the Plan: Employees covered by a collective bargaining agreement as to which retirement benefits were the subject of good faith bargaining, unless such agreement expressly provides for participation in the Plan, Non-resident aliens with no US source of income, "Leased employees" within the meaning of Section 414(n), Part-time employees who regularly work less than 30 hours per week, Seasonal employees who regularly work less than 6 months per year, and self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

### **How do I become a Participant and when is my Entry Date?**

After you satisfy the eligibility requirements described under 'What are the Eligibility Requirements to participate in the Cafeteria Plan?', you may enter the plan on the date the eligibility requirements have been met by signing an individual Election Form/Salary Reduction Agreement. The Election Form/Salary Reduction Agreement will be available by the first day of the Open Enrollment Period. You must complete the Election Form/Salary Reduction Agreement and return it to Your Human Resources Rep within the time period specified in the enrollment materials. (If you have not received the enrollment materials and/or the Election Form/Salary Reduction Agreement, ask Your Human Resources Rep for copies.) An Eligible Employee who fails to complete, sign, and return an Election Form/Salary Reduction Agreement, as required, shall continue with the same elections as the prior year for insured/premium benefits.

Employees who actually participate in the Cafeteria Plan are called "Participants." An Employee continues to participate in the Cafeteria Plan until: (a) termination of the Cafeteria Plan; or (b) the date on which the Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason).

However, for purposes of pre-taxing COBRA coverage for Premium Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See 'What is Continuation Coverage and how does it work?', and 'What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?' for information about how termination of participation affects your Benefits.

### **What is the "Open Enrollment Period" and the "Plan Year"?**

The Open Enrollment Period is the period during which you have an opportunity to participate under the

Cafeteria Plan by signing and returning an individual Election Form/Salary Reduction Agreement.

You will be notified of the timing and duration of the Open Enrollment Period prior to the beginning of the new Plan Year. The Plan Administrator will inform all Participants of the applicable dates for each annual enrollment period.

**What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?**

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Cafeteria Plan will cease and you will not be able to make any more contributions to the Cafeteria Plan for the Premium insurance benefits, Health FSA, and DCAP benefits.

The Premium Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan.

See **'What is Continuation Coverage and how does it work?'** and the booklets for the Medical Insurance Plan for information on your right to continued or converted group health coverage after termination of your employment.

For reimbursement of expenses from the Health FSA Account after termination of employment, see **What must I do to be reimbursed for Medical Care Expenses from the Health FSA?**

For reimbursement of expenses from the DCAP Account after termination of employment, see **What must I do to be reimbursed for my Dependent Care Expenses?**

For purposes of pre-taxing COBRA coverage for Premium Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See **What is Continuation Coverage and how does it work?**

If you are rehired within 30 days or less during the same Plan Year and are eligible for the Cafeteria Plan, then your prior elections will be reinstated.

If you are rehired more than 30 days after you terminated employment, but within same Plan Year and are eligible for the Cafeteria Plan, you will be treated as a new hire and must re-satisfy (complete the waiting period) Plan eligibility requirements to rejoin the Plan. Any unused reimbursement benefit account balance prior to the initial separation of service date will be forfeited.

If you cease to be an Eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described under **'How can I participate in the Cafeteria Plan?'** before again becoming eligible to participate in the Plan.

**What is "Continuation Coverage" and how does it work?**

To the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the medical insurance plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), may be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the medical insurance plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for medical insurance benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either: (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for medical insurance benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and

consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

To the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, who has a separation from service or whose coverage terminates under the Health FSA Benefit because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) may be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Benefit the day before the qualifying event for the periods prescribed by COBRA.

Specifically, such individuals may be eligible for COBRA continuation coverage only if they have a positive Health FSA Account balance at the end of the applicable Period of Coverage (taking into account all claims submitted before the date of the qualifying event).

Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the applicable Period of Coverage; such COBRA coverage for the Health FSA Benefit will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Notwithstanding the foregoing, a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Benefit on the last day of a Plan Year may be entitled to reimbursement of Medical Care Expenses incurred during the Grace Period following that Plan Year as described under 'When must the Medical Care Expenses be incurred for the Health FSA?.'

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

#### **USERRA**

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

#### **How does a leave of absence (such as under 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), then to the extent required by the FMLA your Employer will continue to maintain your Premium insurance benefits, and Health FSA benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Premium Insurance Benefits and Health FSA Benefits coverage while you 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 contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

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 Premium Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of the following ways: (a) with after-tax dollars while on leave; (b) with pre-tax dollars to the extent that you receive compensation during the leave, or by pre-



paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan 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 Premium Insurance Benefits and Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions 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, depending on what you and the Plan Administrator agree to. If your Premium Insurance Benefits or Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave.

But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was 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 contributions. 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, then your election for non-health benefits (such as DCAP 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 (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

### **Article III**

## **PAYING FOR YOUR BENEFITS UNDER YOUR PLAN**

#### **How do employees pay for benefits on a pre-tax basis?**

An Employee's election to pay for benefits on a pre-tax or after-tax basis is made by entering into an Election Form/Salary Reduction Agreement with the Employer (ask Your Human Resources Rep for a copy if you have not received one). Under that Agreement, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

#### **Will I pay any administrative costs under the Cafeteria Plan?**

No. The cost of the plan includes administrative expenses and is paid entirely by the Employer. The cost of the plan includes administrative expenses and is paid in part by the use of forfeitures, if any. (See **Health FSA See What are the time limits that affect forfeiture of my Health FSA Benefits?** and **What are the time limits that affect forfeiture of my DCAP Benefits?**) The rest of the cost of administering the Cafeteria Plan is paid entirely by the Employer.

#### **Can I change my elections under the Cafeteria Plan during the Plan Year?**

You generally cannot change your election to participate in the Cafeteria Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year.

During the Plan Year, however, there are several important exceptions to the irrevocability rule. See the various "Change in Election Events" that are described under **When Can I Change Elections Under the Cafeteria Plan?**. The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Cafeteria Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Cafeteria Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

#### **When can I change elections under the cafeteria plan during the Plan Year?**

Participants can change their elections under the Cafeteria Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various 'Change in Election Events' headings below for the specific type of Change in Election Event:

Leaves of absence, including FMLA leave (defined under **How do leaves of absence (such as under FMLA) affect my benefits?**); Changes in Status; Special Enrollment Rights; Certain Judgments, Decrees, and Orders; Medicare or Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence.

If the change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

### **1. Leaves of Absence**

*(Applies to Medical Insurance Benefits, Health FSA, and DCAP Benefits)*

You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described under **How do leaves of absence (such as under FMLA) affect my benefits?**

### **2. Change in Status.**

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

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

### **3. Change in Status-Other Requirements.**

*(Applies to Medical Insurance Benefits, Health FSA, and DCAP Benefits)*

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for DCAP Benefits, the event may also affect eligibility of Dependent Care Expenses (as defined under **What are "Dependent Care Expenses" that may be reimbursed?**) for the dependent care tax exclusion).

Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age). But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed. For example, assume that you elected

to contribute \$100 per month to the Health FSA and in February you were reimbursed for expenses in the amount of \$700. If a Change in Status Event occurs in March that allows you to cancel coverage, your cancellation will not take effect until you have contributed a total of \$700 for the year. (See also 'How are my Health FSA Benefits paid for under the Cafeteria Plan?' and 'What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?'.)

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

- \* ***Loss of Spouse or Dependent Eligibility; Special COBRA Rules.*** For accident and health benefits (the Medical Insurance Plan 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.

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

However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Cafeteria Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See **What Is "Continuation Coverage" and how does it work?**.

- \* ***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 Cafeteria Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.
- \* ***DCAP Benefits.*** With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

**Example:** Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a DCAP as part of its cafeteria plan. Mike elects to reduce his salary by

\$2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the DCAP. This event constitutes a Change in Status. Mike's election to cancel coverage under the DCAP would be consistent with this Change in Status.

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

**5. Certain Judgments, Decrees, and Orders.** *(Applies to Medical Insurance Benefits and Health FSA Benefits)* If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits or Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

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

**7. Change in Cost.** *(Applies to Medical Insurance Benefits and DCAP Benefits)* If the cost charged to you for your Medical Insurance Benefits or DCAP Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefit package option provides similar coverage. (Note that, for purposes of this definition, (a) the Health FSA is not similar coverage with respect to the Medical Insurance Benefits; (b) an HMO and a PPO are considered to be similar coverage (the Employer currently offers an HMO and a PPO); and (c) coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.)

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator generally will notify you of increases in the cost of Medical Insurance benefits; you generally will have to notify the Plan Administrator of increases in the cost of DCAP benefits. The change in cost provision applies to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

**8. Change in Coverage.** *(Applies to Medical Insurance Benefits and DCAP Benefits)* You may also change your election if one of the following events occurs:

- \* **Significant Curtailment of Coverage.** If your Medical Insurance Benefits and DCAP Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an

overall reduction of coverage under the plan generally-loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits and DCAP Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage.) you generally will have to notify the Plan Administrator of significant curtailments in DCAP Benefits coverage.)

- \* *Addition or Significant Improvement of Cafeteria Plan Option.* If the Cafeteria Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.
- \* *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- \* *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria 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, which it does. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.
- \* *DCAP Coverage Changes.* You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

## Article IV WHAT BENEFITS ARE PROVIDED UNDER THE PLAN

### **What benefits may be elected under the Cafeteria Plan?**

The Cafeteria Plan includes the following benefit plans:

*Premium Payment Component (currently including Premium Insurance Benefits)* - permits an Employee to pay for his or her share of contributions for the Medical Insurance Plan with pre-tax dollars. "Medical Insurance Plan" means the major medical plan that your Employer maintains for Employees, their Spouses, and Dependents, providing major medical type benefits through a group insurance policy.

Here, these benefits include PPO, Dental, and Vision options. Benefits provided under the Medical Insurance Plan are called "Premium Insurance Benefits." Benefits provided generally under the Premium Payment Component (including any benefits that may be added at a later date) are called "Premium Payment Benefits";

*Health Flexible Spending Arrangement (Health FSA)* also called a medical expense reimbursement plan - permits an Employee to pay for his or her qualifying Medical Care Expenses (defined under **What are Medical Care Expenses that may be reimbursed from the Health FSA?**) that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits provided under the Health FSA are called "Health FSA Benefits." As described under **What are Medical Care Expenses that may be reimbursed from the Health FSA?**, the Health FSA election may be for:

- \* General-Purpose Health FSA Coverage.

*Dependent Care Assistance Program (DCAP)* also called a dependent care flexible spending account - permits an Employee to pay for his or her qualifying Dependent Care Expenses (defined under **What are Dependent Care Expenses that may be reimbursed?**) with pre-tax dollars. Benefits provided under the DCAP are called "DCAP 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.

## Article V HOW BENEFITS ARE TAXED

### What tax savings are possible under the Cafeteria Plan?

You may save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. Here is an example of the possible tax savings of paying for your share of the contributions for Premium Insurance Benefits under the Cafeteria Plan. Suppose that you are married and have one child and that your share of the required contributions for Premium Insurance Benefits for family coverage is an annual total of \$6,400. Suppose also that your gross pay is \$75,000 and your Spouse (a student) earns no income and that you file a joint tax return.

As illustrated in detail by the Table below, if you elect to salary-reduce \$6,400 to pay for the Premium Insurance contributions, then your annual take-home pay would be \$56,732. If instead you elect to pay the contributions on an after-tax basis, then your annual take-home pay would be only \$55,282. This is because by participating in the Cafeteria Plan for Premium Insurance contributions, you will be considered for tax purposes to have received \$68,600 in gross pay, so you save \$1,450 per year. How much an employee actually saves will depend on what family members are covered and the contributions for the coverage, the total family income, and the tax deductions and exemptions claimed. There may be state tax savings, too. And salary reductions also lower earned income, which can impact the earned income credit for eligible taxpayers.

**Caution:** The amount of the contributions used in this example is not meant to reflect your actual contributions-the actual contribution amounts will be determined by you.

	Cafeteria Plan*	No Cafeteria Plan
1. Adjusted Gross Income	\$75,000	\$75,000
2. Salary Reductions for Premiums	(\$6,400)	\$0
3. W-2 Gross Wages	\$68,600	\$75,000
4. Standard Deduction	(\$10,000)	(\$10,000)
5. Exemptions	(\$9,600)	(\$9,600)
6. Taxable Income (line 3 minus lines 4 & 5)	\$49,000	\$55,400
7. W-2 Gross Wages	\$68,600	\$75,000
8. Federal Income Tax (line 6 @ tax schedule)	(\$6,620)	(\$7,850)
9. FICA Tax (7.65% of line 3)	(\$5,248)	(\$5,738)
10. After-Tax Premium Payments	\$0	(\$6,400)
11. Pay After Taxes and Premium Payments (line 7 minus lines 8, 9 & 10)	\$56,732	\$55,282

\* The standard deduction, exemptions, and federal income tax rates for 2007 are found in IRS Rev. Proc. 2004-71, 2004-50 I.R.B. 970. The FICA tax rate is found at <http://www.ssa.gov/pressoffice/factsheets/colafacts2007.htm> (as visited March 23, 2007).

### How will participating in the Cafeteria Plan affect my Social Security and other benefits?

Participating in the Cafeteria Plan 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 Cafeteria Plan participation will often more than offset any reduction in other benefits.

### Will I be taxed on the Health FSA Benefits that I receive?

Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth under **What are the**



**maximum Health FSA Benefits that I may elect?** However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, then you will be required to repay the amount.

**Will I be taxed on the DCAP Benefits I receive?**

Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth under **What are the maximum and minimum DCAP Benefits that I may elect under the Cafeteria Plan?** However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 ("Child and Dependent Care Expenses") with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the DCAP constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are, and are not likely to be reimbursable.

## **Article VI**

### **PREMIUM INSURANCE BENEFIT ACCOUNT**

#### **What are "Premium Payment Benefits"?**

As described under 'How do employees pay for benefits on a pre-tax basis?', if you elect Premium Payment Benefits you will be able to pay for your share of contributions for Premium Insurance Benefits with pre-tax dollars 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. See 'How Benefits Are Taxed?'.

The only Premium Payment Benefits offered under your Plan are for Premium Insurance Benefits, this is major medical insurance, including PPO, Dental, and Vision options.

#### **How are my Premium Payment Benefits paid?**

As described under 'How do employees pay for benefits on a pre-tax basis?' and 'What are "Premium Payment Benefits?', if you select the Medical Insurance Plan described under 'What are Premium Payment Benefits?', then you may be required to pay a portion of the contributions. When you complete the Election Form/Salary Reduction Agreement, if you elect to pay for benefits on a pre-tax basis you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay 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).

## **Article VII**

### **HEALTH FSA REIMBURSEMENT ACCOUNT**

#### **What are "Health FSA Benefits"?**

As described under **'What benefits may be elected under the Cafeteria Plan?**, a Health FSA permits Eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Medical Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from the Medical Insurance Plan).

As described under **'How do employees pay for benefits on a pre-tax basis?**, if you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses 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. See **'What tax savings are possible under the Cafeteria Plan?** for an example dealing with pre-tax payment of Premium Insurance contributions. Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not reimbursed elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

After you satisfy the eligibility requirements described above, you may participate in the Health FSA on the date the eligibility requirements have been met by signing an individual Election Form/Salary Reduction Agreement as described under **'How do I become a Participant and when is my Entry Date?**

#### **What is my "Health FSA Account"?**

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

A Health FSA election may be for:

- General-Purpose Health FSA Coverage.

In addition, because the Health FSA includes a grace period, if you have an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option) that is in effect on the last day of a Plan Year, you cannot elect HSA Benefits or otherwise make contributions to an HSA for any of the first three calendar months following the close of that Plan Year unless the balance of your Health FSA Account is zero at the end of that Plan Year.

Additionally, unless you have elected Employee-Only or Employee-Plus-Children Health FSA Coverage, your spouse (if you are married) will also be unable to make HSA contributions during this period. See **'What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?** for more information.

#### **How are my Health FSA Benefits paid for under the Cafeteria Plan?**

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). For example, suppose that you have elected to be reimbursed up to \$1,000 per year

for Medical Care Expenses and that you have chosen no other benefits under the Cafeteria Plan. If you pay all of your contributions, then your Health FSA Account would be credited with a total of \$1,000 during the Plan Year. If you are paid bi-weekly, then your Health FSA Account would reflect that you have paid \$38.46 (\$1,000 divided by 26) each pay period in contributions for the Health FSA Benefits that you have elected. The Employer makes no contribution to your Health FSA Account.

**What are the maximum 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 of \$3,900.00 under the General-Purpose Health FSA per Plan Year. You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen.

If a Participant enters the Health FSA mid-year, then the Participant's maximum reimbursement dollar limit will be prorated based on a percentage of the Plan Year remaining.

**What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?**

The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). For example, suppose that you elected \$1,000 of coverage and contributed to your Health FSA Account (as described under **How are my Health FSA Benefits paid for under the Cafeteria Plan?**) during January and February—that means that by February 24 you would have contributed \$153.84 (\$38.46 times four pay periods). You haven't made any prior claims for reimbursement during the calendar year, but on February 26 you incur a Medical Care Expense in the amount of \$300. You submit that claim for reimbursement on February 27. So long as the claim meets all applicable requirements, the \$300 would be available to you for that expense, even though you have only contributed \$153.84 to your Health FSA Account at that point.

However, only reasonable quantities of over-the-counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar month, even if the drugs otherwise meet the requirements for reimbursement, including that they are for medical care under Code § 213(d). Stockpiling is not permitted.

You may also be able to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year for Medical Care Expenses incurred during a "grace period" following the end of the Plan Year. (See **When must the Medical Care Expenses be incurred for the Health FSA?**)

**What are "Medical Care Expenses" that may be reimbursed from the Health FSA?**

Your Health FSA election may be for:

- \* General-Purpose Health FSA Coverage.

Each of these Health FSA coverage options is described in detail below.

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 OTC drugs

and medicines as well as expenses for prescription drugs. However, as described above, only reasonable quantities of over-the-counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar month. The following list specifies certain expenses that are not reimbursable, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses that are not on the list of exclusions below will still not be reimbursable if such expenses do not meet the definition of "medical care" under Code § 213(d) and other requirements for reimbursement under the Health FSA.

**EXCLUSIONS:**

- \* health insurance premiums for any other plan (including premiums for a plan sponsored by the Employer, such as the Medical Insurance Plan);
- \* long-term care services;
- \* cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- \* the salary expenses of a nurse to care for a healthy newborn at home;
- \* funeral and burial expenses;
- \* household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework);
- \* custodial care;
- \* costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods;
- \* social activities, such as dance lessons (even if recommended by a physician for general health improvement);
- \* bottled water;
- \* cosmetics, toiletries, toothpaste, etc.;
- \* uniforms or special clothing, such as maternity clothing;
- \* automobile insurance premiums;
- \* marijuana and other controlled substances that are in violation of federal law, even if prescribed by a physician;
- \* any item that doesn't constitute "medical care" under Code § 213(d); and
- \* any item that isn't reimbursable under applicable regulations.

Ask the Plan Administrator if you need further information regarding which expenses are reimbursable under your plan.

For purposes of the Health FSA and its Coverage Options, "Spouse" means the person who is legally married to you and is treated as a spouse under the Code. "Dependent" means your tax dependent under the Code, except that an individual's status as a Dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition. See the Plan Administrator for more information about which individuals will qualify as your Dependents.

**Note:** Because of recent changes in the Code, some individuals' Medical Care Expenses may no longer qualify for tax-free reimbursement under a Health FSA. Your child (and in some cases, your stepchild, grandchild, brother, sister, stepbrother, stepsister, niece, or nephew) may no longer be considered to be your Dependent if he or she has the same principal place of abode with another person for more than half the year. For example, if you provide more than half of your child's support, but he or she lives with a grandparent all year, then your child could be the grandparent's tax dependent instead of yours (if other conditions are met). If you have children (or stepchildren, grandchildren, etc.) who do not reside with you and who are affected by this change, their expenses will no longer be eligible for tax-free reimbursement under the Health FSA. Other changes may apply as well to individuals who were previously

eligible for tax-free Health FSA coverage.

**When must the Medical Care Expenses be Incurred for the Health FSA?**

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

In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year for Medical Care Expenses incurred during a "grace period" following the end of the Plan Year. Grace periods will begin immediately following the last day of the plan year and will end 2.5 months later.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the Health FSA or the Cafeteria Plan became effective, before your Election Form/Salary Reduction Agreement became effective, for any expense incurred after the close of the Plan Year (except for certain expenses incurred during a grace period, as discussed below), or after a separation from service (except for Continuation Coverage, as described under **What Is "Continuation Coverage" and how does it work?**).

In order to take advantage of the grace period, you must be:

- \* a Participant in the Plan with Health FSA coverage that is in effect on the last day of the Plan Year to which the grace period relates (March 31st); or
- \* a qualified beneficiary who has COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates (March 31st).

See **'What must I do to be reimbursed for Medical Care Expenses from the Health FSA?** regarding certain rules that apply to claims for reimbursement for Medical Care Expenses that are incurred during a grace period.

**Can I Continue Health FSA Coverage After Terminating Employment or Incurring a COBRA Event?**

The only way a Participant and his or her Spouse and Dependents, as applicable, may continue the same coverage that he or she had under the Health FSA Benefit before the qualifying event, is to elect COBRA either on a self-pay basis or, if applicable, or to continue with salary reductions.

Please note that this only applies if you have a positive Health FSA Account balance at the end of the applicable Period of Coverage (taking into account all claims submitted before the date of the qualifying event).

Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the applicable Period of Coverage. COBRA coverage generally ends for the Health FSA Benefit at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Please refer to your COBRA Notice for further explanation regarding your specific situation.

Contributions for COBRA continuation for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year. Generally for Employees who have incurred a COBRA qualifying event as a result of no longer being actively employed, payments must be made on an

after-tax basis.

**What must I do to be reimbursed for Medical Care Expenses from the Health FSA?**

When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a Health FSA Reimbursement Request 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 stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Generally, this requires including an Explanation of Benefits (EOB) Form from the insurance provider (or a bill from a doctor's office) indicating the amounts that you are obligated to pay. Further details about what must be provided are contained in the Health FSA Reimbursement Request Form. If you have paid the contributions for the Health FSA coverage that you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 90 days after the date you submitted the Health FSA Reimbursement Request Form (subject to a 15 day extension for matters beyond the Plan Administrator's control-see **What happens if my claim for benefits is denied?**). Claims will be paid in the order in which they are approved. Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

You will have until the 90th day after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 90 days after the date you ceased to be eligible in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible (or during any applicable grace period). You will be notified in writing if any claim for benefits is denied. (See **What happens if my claim for benefits is denied?**)

The Health FSA Benefit has a grace period which allows for an additional period of time of 2.5 months following the end of each Plan Year to incur expenses before the "use it or lose it" forfeiture rule applies. Thus, expenses incurred within 2.5 months after the close of the Plan Year can be reimbursed with funds carried over from the prior Plan Year.

The following additional rules will apply to Medical Care Expenses that are incurred during a grace period or are submitted after the close of the Plan Year in which they were incurred:

- \* If a claim is made for Medical Care Expenses incurred during a grace period and approved for reimbursement, you may designate, at the time a claim is presented to the Plan Administrator, against which Plan Year(s) you want the claim paid against. Once paid, a claim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the \$500 grace period expense, you discover \$200 of 2007 Medical Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2008 expenses. The Plan will not reprocess the \$500 grace period expense so as to pay it entirely from your 2008 Health FSA amounts. For this reason, if you also have health FSA coverage for the current year, you may want to wait to submit Medical Care Expenses you incur during the grace period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year. If you either choose to have the claim adjudicated against all applicable Plan Years, or fail to designate against which Plan Year(s) each particular claim is to be paid, such claim(s) will first be charged to the Account that relates to the Plan Year associated with the Grace Period. If any part of a claim for a Medical Expense remains unpaid it will next be charged to the Account relating to the Plan Year in which such Medical Expense was incurred. Once a claim is adjudicated in this manner, it shall be irrevocable and cannot be reprocessed against a different Plan Year.
- \* Expenses incurred during a grace period must be submitted by the 90 day(s) following the close of the Plan Year to which the grace period relates in order to be reimbursed from amounts remaining at the end of that Plan Year. (As discussed above, 90 days is also the deadline for submitting any claims for reimbursement of Medical Care Expenses incurred

during the preceding Plan Year.)

To have your claims processed as soon as possible, please read **What happens if my claim for benefits is denied?**. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense, only for you to have incurred the expense (as defined under **When must the Medical Care Expenses be Incurred for the Health FSA?**) and that it is not being paid for or reimbursed from any other source.

If the Employer implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Health FSA, some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents. In addition, Medical Care Expenses incurred during a Grace Period may need to be submitted manually in order to be reimbursed from unused amounts in your Health FSA Account from the preceding Plan Year if the card is unavailable for such reimbursement. You will receive more information from the Employer about what you must do to obtain reimbursement if such a system is implemented.

**Is there any risk of losing or forfeiting the amounts that I elect for Health FSA Benefits?**

Yes. If the Medical Care Expenses that you incur during the Plan Year or during the grace period immediately following the Plan Year (if you are eligible for the grace period- see **When must the Medical Care Expenses be Incurred for the Health FSA?**) are less than the annual amount that you elected for Health FSA Benefits, you will forfeit the rest of that amount-this is called the "use-it-or-lose-it" rule under applicable tax laws. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Medical Care Expenses during the Plan Year or its grace period, if applicable, even if amounts are still left in your Health FSA Account. The difference between what you elected and what Medical Care Expenses were reimbursed will be forfeited at the end of the time limits described under **What are the time limits that affect forfeiture of my Health FSA Benefits?**.

**What are the time limits that affect forfeiture of my Health FSA Benefits (and what happens to amounts that are forfeited)?**

You will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted by the 90th day following the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you may forfeit such amounts at an earlier date-see **What must I do to be reimbursed for Medical Care Expenses from the Health FSA?**). Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the Health FSA during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. 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 above.

**Will I be taxed on the Health FSA Benefits that I receive?** Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth under **What are the maximum and minimum Health FSA Benefits that I may elect?**. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, then you will be required to repay the amount.

Ask the Plan Administrator if you need further information about which expenses are and are not likely to be reimbursable.



## **Article VIII DEPENDENT CARE REIMBURSEMENT ACCOUNT**

### **What are "DCAP Benefits"?**

As described under 'What benefits may be elected under the Cafeteria Plan?', a DCAP permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your Spouse's DCAP). As described under 'How do employees pay for Benefits on a pre-tax basis?', if you elect DCAP Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See 'What tax savings are possible under the Cafeteria Plan?' for an example dealing with pre-tax payment of Premium Insurance contributions.

After you satisfy the eligibility requirements described above, you may participate in the DCAP on the date the eligibility requirements have been met by signing an individual Election Form/Salary Reduction Agreement as described under 'How do I become a Participant and when is my Entry Date?'

### **What is my "DCAP Account"?**

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

### **What are the maximum DCAP Benefits that I may elect under the Cafeteria Plan?**

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual DCAP contribution equal to the coverage level that you have chosen (e.g., if you elect \$3,000 in DCAP Benefits, you'll pay for the benefits with a \$3,000 salary reduction). The amount of Dependent Care Expense reimbursement that you choose cannot exceed \$5,000 for a calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code § 129 when your election is made. The \$5,000 maximum will apply to you if:

- \* you are married and file a joint federal income tax return;
- \* you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the DCAP); (2) you furnish over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of such household (i.e., your Spouse maintained a separate residence); or
- \* you are single or the head of the household for federal income tax purposes. If you are married and reside with your Spouse but you file a separate federal income tax return, then the maximum DCAP Benefit that you may exclude from your income under Code § 129 is \$2,500 for a calendar year. These maximums (\$5,000 or \$2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations, as described under 'What are "Dependent Care Expenses" that may be reimbursed?' (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

If a Participant enters the DCAP mid-year, then the Participant's maximum reimbursement dollar limit will be prorated based on a percentage of the Plan Year remaining.

**How are my DCAP Benefits paid for under the Cafeteria Plan?**

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

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

**What amounts will be available for DCAP reimbursement at any particular time during the Plan Year?**

The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year.

Using the example under 'How are my DCAP Benefits paid for under the Cafeteria Plan?', suppose that you incur \$1,500 of Dependent Care Expenses by the end of March. At that time, your DCAP Account would only have been credited with \$700 (\$100 times seven pay periods), so only \$700 would be available for reimbursement at the end of March (assuming that you had not received any prior reimbursements). You would have to wait to submit the remaining \$800 in Dependent Care Expenses until after you had received the appropriate credits to your DCAP Account (you could request a \$100 reimbursement after each of the next eight pay periods).

You may also be able to be reimbursed from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a "grace period" following the end of the Plan Year. (See 'When must the Dependent Care Expenses be Incurred for the DCAP?')

**What are "Dependent Care Expenses" that may be reimbursed?**

"Dependent Care Expenses" means employment-related expenses incurred on behalf of a person who meets the requirements to be a "Qualifying Individual," as defined in the first bulleted item below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

- \* Each person for whom you incur the expenses must be a Qualifying Individual, that is, he or she must be:
  - a person under age 13 who is your "qualifying child" under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year); or
  - your Spouse or a person who is your dependent under federal tax law, but only if he or she is physically or mentally incapable of self-care and has the same principal abode as you for more than half the year.

Under a special rule for children of divorced or legally separated parents, a child is a Qualifying Individual with respect to the custodial parent, even if that parent is not entitled to claim the dependency exemption for the child. See the Plan Administrator for more information which individuals will qualify as your Qualifying Individuals.

Note that recent legislation has changed the tests that apply for a child, Spouse, or other person to be a Qualifying Individual. For example, to be a Qualifying Individual based on being physically or mentally incapable of self-care, a dependent's gross income must be less than the exemption amount (for 2005, \$3,200 (before phase-out)). This requirement does not apply to a Spouse or qualifying child (of any age) who is physically or mentally incapable of self-care.

(For this purpose, a qualifying child is a person who meets the requirements described above and is under 19, under 24 and a full-time student, or permanently and totally disabled.) Other changes may apply as well to persons who were previously Qualifying Individuals.

- \* No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP Account.
- \* The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.
- \* The expenses are incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care.
- \* The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.
- \* If the expenses are incurred for services outside of your household, they are incurred for the care of (a) a person under age 13 who is your qualifying child; or (b) your Spouse or a person who is your dependent under federal tax law, is physically or mentally incapable of self-care, and regularly spends at least eight hours per day in your household.
- \* If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- \* The person who provided care was not your Spouse or a person for whom you are entitled to a personal exemption under Code § 151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- \* The expenses are not paid for services outside of your household at a camp where the dependent stays overnight.

Ask the Plan Administrator if you need further information about which expenses are, and are not, likely to be reimbursable.

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

- \* your earned income for the calendar year (after your salary reductions under the Cafeteria Plan);
- \* the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of \$250 (\$500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care; or (b) a full-time student); or
- \* either \$5,000 or \$2,500 for the calendar year, depending on your marital and tax filing status, as described further under *What are the maximum and minimum DCAP Benefits that I may elect under the Cafeteria Plan?*

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

#### **When must the Dependent Care Expenses be Incurred?**

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

In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a "grace period" following the end of the Plan Year. Grace periods will begin immediately following the last day of the plan year and will end 2.5 months later.

A Dependent Care Expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for dependent care that will be given during the rest of the month, then the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the DCAP or Cafeteria Plan became effective, for any expenses arising 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 as described under **What must I do to be reimbursed for my Dependent Care Expenses?**).

#### **Can I Continue DCAP Coverage After Terminating Employment?**

When you cease to be a Participant under the DCAP Benefit, your salary reductions and election to participate will terminate also. Therefore, the Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible.

**What must I do to be reimbursed for my Dependent Care Expenses?** When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a DCAP Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and stating the amount of such Dependent Care Expenses, along with the DCAP Reimbursement Request Form. Further details about what must be provided are contained in the DCAP Reimbursement Request Form.

If there are enough credits to your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the DCAP Reimbursement Request Form (subject to a 45-day extension for matters beyond the Plan Administrator's control-see **What happens if my claim for benefits is denied?**). If a claim is for an amount larger than that remaining in your current DCAP Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your DCAP Account.

You will have until 90 days after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 90 days after the date you ceased to be eligible in which to submit a claim for reimbursement for Dependent Care Expenses incurred prior to the date you ceased to be eligible; you can also be reimbursed for expenses incurred in the month following your termination of participation if such month is in the current Plan Year and your claim is submitted by the 90 day deadline. You will be notified in writing if any claim for benefits is denied. (See **What happens if my claim for benefits is denied?**.)

This benefit has a grace period which allows for an additional period of time of 2.5 months following the end of each Plan Year to incur expenses before the "use it or lose it" forfeiture rule applies. Thus, expenses incurred within 2.5 months after the close of the Plan Year can be reimbursed with funds carried over from the prior Plan Year. However, any unused amounts from the prior Plan Year that are not used to reimburse expenses by the end of the grace period remain subject to the "use it or lose it" rule and must be forfeited.

In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Dependent Care Expenses during the Plan Year, even if amounts are still left in your DCAP Account. The difference between what you elected and what Dependent Care Expenses were reimbursed will be forfeited at the time periods described under **What are the time limits that affect forfeiture of my DCAP Benefits?**

**What are the time limits that affect forfeiture of my DCAP Benefits?**

You will forfeit any amounts in your DCAP Account that are not applied to DCAP Benefits for any Plan Year by the 90th day following the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you will forfeit such amounts if they have not been applied within days after the date you ceased to be eligible-see **What must I do to be reimbursed for my Dependent Care Expenses?**). Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the DCAP during the Plan Year and the subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. Also, any DCAP 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 Dependent Care Expense was incurred shall be forfeited and applied as described above.

**Will I be taxed on the DCAP Benefits I receive?**

Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth under **What are the maximum and minimum DCAP Benefits that I may elect under the Cafeteria Plan?** However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 ("Child and Dependent Care Expenses") with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the DCAP constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are, and are not likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice.

**If I elect DCAP Benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return?**

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit (see **What is the Dependent Care Tax Credit?**). For example, if you elect \$3,000 in coverage under the DCAP and are reimbursed \$3,000, but you had Dependent Care Expenses totaling \$5,000, then you could count the excess \$2,000 when calculating the Dependent Care Tax Credit if you have two or more Dependents.

**What Is the Dependent Care Tax Credit?**

The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual Dependent Care Expenses. In determining what the tax credit would be, you may take into account \$3,000 of such expenses for one Dependent or \$6,000 for two or more Dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of \$1,050 for one Dependent or \$2,100 for two or more Dependents), to a minimum of 20% of such expenses (producing a maximum credit of \$600 for one Dependent or \$1,200 for two or more Dependents). The maximum 35% rate is reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) by which your adjusted gross incomes exceeds \$15,000.

Example: Assume that you have one Dependent for whom you have incurred Dependent Care Expenses of \$3,600, and that your adjusted gross income is \$20,000. Since only one Dependent is involved, the credit will be calculated by applying the appropriate percentage to the first \$3,000 of the expenses. The percentage is 32%. Thus, your tax credit would be  $\$3,000 \times 32\% = \$960$ . If you had incurred the same expenses for two or more Dependents, your credit would have been  $\$3,600 \times 32\% = \$1,152$ , because the entire expense would have been taken into account, not just the first \$3,000.

For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses").

**Would It be better to include the DCAP Benefits in my income and claim the Dependent Care Tax Credit, Instead of treating the reimbursements as tax free?**

For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of Dependents, earned income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 ("Child and Dependent Care Expenses") to help you.

Ask the Plan Administrator if you need further information about the DCAP or the Dependent Care Tax Credit, but remember that the Plan Administrator is not providing legal advice. Your Employer may also be able to provide you with a worksheet or tax calculator to help you make the comparison, ask the Human Resources Manager if you would like to use one or both of these.

## **Article IX CLAIMS PROCEDURE**

### **What happens if my claim for benefits is denied?**

#### *Premium Insurance Benefits*

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

#### *Claims Under the Cafeteria Plan*

However, if (a) a claim for reimbursement under the Health FSA or DCAP Components of the Cafeteria Plan is wholly or partially denied, or (b) you are denied a benefit under the Cafeteria Plan (such as the ability to pay for Premium insurance benefits, Health FSA, and DCAP benefits on a pre-tax basis) due to an issue germane to your coverage under the Cafeteria Plan (for example, a determination of a Change in Status; a "significant" change in contributions charged; or eligibility and participation matters under the Cafeteria Plan document), then the claims procedure described below will apply. If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

#### **Notification of a denied claim will set out:**

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

#### *Appeals*

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

#### *Decision on Review*

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in

connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided.

If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

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

*Duty of Beneficiary/Third Party Recoveries*

Any Beneficiary under the Plan that receives a payment, whether by lawsuit, settlement, or otherwise, from third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party must reimburse the Plan to the extent the Beneficiary has received payments from the Plan for such sickness or injury. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

The Plan further requires covered Beneficiaries promptly advise the Plan Administrator of third-party claims and to execute any assignments, liens, or other documents the Plan Administrator requests. The Plan may withhold Benefits until such documents are received.

*Subrogation/Acts of Third Parties*

The Plan Administrator, on behalf of the Plan, has the right to recover any payments made to Beneficiaries, whether by lawsuit, settlement, or otherwise, by third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.



## **Article X FUNDING**

### **Funding This Plan**

All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

### **How long will the Cafeteria Plan remain in effect?**

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

## **Article XI**

### **STATEMENT OF ERISA RIGHTS**

#### **What are my ERISA Rights?**

The Cafeteria Plan and the HSA Component are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and the Medical Insurance Plan are governed by ERISA.

**Note:** This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan document and the separate Summary Plan Description for the Medical Insurance Plan.

**Your Rights.** As a participant in the Cafeteria Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

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

**COBRA and HIPAA Rights.** You have a right to continue your Medical Insurance Plan coverage (and, in some cases, your Health FSA coverage) for yourself 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.

You have rights regarding reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (Note: This does not apply to the Health FSA, which is an "excepted benefit" under HIPAA.)

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

**Fiduciary Obligations.** In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits 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 participants.

**No Discrimination.** 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.

**Right to Review.** 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.

**Enforcing Your Rights.** Under ERISA, there are steps that you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive them, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, then you may file suit in a state or federal court (but only if you have first filed your claim under the plan's claims 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 Plan Administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **Article XII GENERAL INFORMATION**

### **What other general information should I know?**

This question contains certain general information that you may need to know about the Plan. **Note:** This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan documents and the separate Summary Plan Description for the Medical Insurance Plan.

### **General Plan Information**

- \* Name: Natural Gas Services Group, Inc. Cafeteria Plan
- \* Plan Number: 501
- \* Effective Date: April 1, 2009
- \* Plan Year: April 1st to March 31st. Your Plan's records are maintained on this 12-month period of time.
- \* Type of Plan: Fringe Benefit and Welfare plan providing Benefits
- \* Your plan shall be governed by the Laws of the State of Texas

### **Employer/Plan Sponsor Information**

- \* Name and Address: Natural Gas Services Group, Inc.  
508 W. Wall St., Suite 550  
Midland, TX 79701  
(432) 262-2700
- \* Federal Employer Tax Identification Number (EIN): 75-2811855

### **Plan Administrator Information**

Name, address, and business telephone number:  
Natural Gas Services Group, Inc.  
508 W. Wall St., Suite 550  
Midland, TX 79701  
(432) 262-2700

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

### **Funding and Type of Plan Administration**

A third-party administrator processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan.

All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy.

Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

### **Named Fiduciary**

The named fiduciary for the Health FSA Component is: Your Human Resources Rep

**Agent for Service of Legal Process**

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

Natural Gas Services Group, Inc.  
Attn: Legal  
508 W. Wall St., Suite 550  
Midland, TX 79701  
(432) 262-2700

**Qualified Medical Child Support Order**

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

**Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)**

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Women's Health and Cancer Rights Act of 1998 (WHCRA)**

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

**Medical Insurance Plan Documents and Information**

This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan document and the separate Summary Plan Description for the Medical Insurance Plan.



## **Plan Amendment & Summary of Material Modification to Natural Gas Services Group, Inc Employee Benefits Plan Document & Summary Plan Description**

Effective Date: September 23, 2013

This Plan Amendment and Summary of Material Modification (SMM) is being delivered to you to be attached to your Plan Document/Summary Plan Description (SPD). You should keep this Plan Amendment and SMM with your Plan Document/SPD for future reference. The changes described below have been adopted and executed by the Company. The changes described in this Amendment and Summary are effective immediately and continue in force until amended by the Company. You can request a copy of your Plan Document/SPD from your Benefits Coordinator. These changes in no way affect any other term or condition stated in your Plan Document/SPD unless that specific term is mentioned below.

This Plan Amendment and Summary of Material Modification (SMM) removes the current section titled **HIPAA Privacy Notice for Self-Insured plan(s)** and replaces it with the following **HIPAA Notice of Privacy Practices**.

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### **HIPAA NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW YOUR PLAN SPONSOR CAN USE OR DISCLOSE YOUR MEDICAL INFORMATION AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) place important restrictions on sharing your medical information and provide you with important privacy rights. This Notice of Privacy Practices (the "Notice") is effective September 23, 2013. It describes the legal obligations of the Plan Sponsor and your legal rights regarding your "protected health information" ("PHI") held by your Plan Sponsor and Group Health Plan. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or other purposes permitted by law.

Generally, PHI includes your personal information collected from you or created by your Group Health Plan, or the Plan Sponsor on behalf of a Group Health Plan, that relates to your past, present, or future physical or mental health or condition; the provision of health care; or the past, present, or future payment for the provision of health care. If you have any questions about this Notice or about our privacy practices, please contact your Human Resources Department identified below.

The Plan Sponsor may retain agents, service providers and third party administrators to administer all or part of your Group Health Plan such as claims payment and enrollment management. The term Plan

Sponsor as used in this Notice includes all entities that provide services related to your Group Health Plan that have access to your PHI.

The Plan Sponsor is required by law to maintain the privacy of your PHI, provide you with certain rights with respect to your PHI, provide you with a copy of this Notice, and follow the terms of this Notice. The Plan Sponsor reserves the right to change the terms of this Notice and its practices regarding your PHI. If there is any material change to this Notice, the Plan Sponsor will provide you with a copy of the revised Notice of Privacy Practices.

### Use and Disclosure

The Plan Sponsor may use or disclose your PHI under certain circumstances without your permission. All of these certain circumstances will fall within one of the categories listed below.

- **For Treatment**, to facilitate medical treatment or services by providers including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.
- **For Payment** to determine your eligibility for Plan benefits, to facilitate payment for the treatment or services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.
- **For Health Care Operations**, uses and disclosures necessary to run the Plan.
- **Treatment Alternatives or Health-Related Benefits and Services** that might be of interest to you.
- **To Business Associates** to perform various functions on our behalf or to provide certain types of services. A Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with the Plan Sponsor to implement appropriate safeguards regarding your PHI.
- **As Required by Law** when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety** to you, or the health and safety of the public, or another person, limited to someone able to help prevent the threat.

In addition, the following categories describe other ways that the Plan Sponsor may use and disclose your PHI without your specific authorization. All of the ways the Plan Sponsor is permitted to use and disclose information will fall within one of the categories.

- **Organ and Tissue Donation**, after your death to organizations that handles organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military**, if you are a member of the armed forces, as required by military command authorities. The Plan Sponsor may also release PHI about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation** or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks** for public health activities. These activities generally include the following:
  - to prevent or control disease, injury, or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if the Plan Sponsor believes that a patient has been the victim of abuse, neglect, or domestic violence. The Plan Sponsor will only make this disclosure if you agree, or when required or authorized by law.
- **Health Oversight Activities** for activities authorized by law. For example, audits, investigations, inspections, and licensure.
- **Lawsuits and Disputes** in response to a court or administrative order, including a response to a lawful subpoena, discovery request, or other process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.
- **Law Enforcement** if asked to do so by a law-enforcement official—
  - in response to a court order, subpoena, warrant, summons, or similar process;
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under certain limited circumstances, the Plan Sponsor is unable to obtain the victim's agreement;
  - about a death that the Plan Sponsor believes may be the result of criminal conduct; and
  - about criminal conduct.
- **Coroners, Medical Examiners, and Funeral Directors**, for example, to identify a deceased person or determine the cause of death. The Plan Sponsor may also release medical information about patients to funeral directors, as necessary to carry out their duties.
- **National Security and Intelligence Activities** to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates** of a correctional institution or in the custody of a law-enforcement official, to the correctional institution or law-enforcement official if necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
- **Research**, to researchers when the individual identifiers have been removed; or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

#### **Required Disclosures**

The Plan Sponsor is required to disclose your PHI to:

- **Government Audits** to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
- **Disclosures to You** on your request, the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

#### **Other Disclosures**

The Plan Sponsor may disclose your PHI to:

- **Personal Representatives** authorized by you, or to an individual designated as your personal representative, or attorney-in-fact. You must provide a written notice/authorization and supporting documents such as a power of attorney. The Plan Sponsor does not have to disclose information to a personal representative if the Plan Sponsor has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or treating such person as your personal representative could endanger you; or in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.
- **Spouses and Other Family Members** relating to the employee's spouse and other family members who are covered under the Plan, and includes information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan



has requested Restrictions or Confidential Communications (see below under “Your Rights”), and if the Plan Sponsor has agreed to the request, the Plan Sponsor will send mail as provided by the request for Restrictions or Confidential Communications.

- **Comply with your Authorization.** Other uses or disclosures of your PHI not described above will only be made with your written authorization. The Plan Sponsor may deny a request to disclose your psychiatric notes. The Plan Sponsor will not use or disclose your PHI for marketing; or sell your PHI, unless you provide written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan Sponsor receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

### Privacy Rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, the Plan Sponsor will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan Sponsor will work with you to come to an agreement on form and format or provide you with a paper copy. To inspect and copy your PHI, you must submit your request in writing to the Human Resources Department identified below. The Plan Sponsor may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. The Plan Sponsor may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Human Resources Department identified below.
- **Right to Amend.** If you feel that your PHI is incorrect or incomplete, you may ask the Plan Sponsor to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Human Resources Department identified below. In addition, you must provide a reason that supports your request. The Plan Sponsor may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Sponsor may deny your request if it:
  - is not part of the medical information kept by or for the Plan;
  - was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
  - is not part of the information that you would be permitted to inspect and copy; or
  - is already accurate and complete.

If your request is denied, you have the right to file a statement of disagreement with the Plan Sponsor and any future disclosures of the disputed information will include your statement.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting” of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Human Resources Department identified below. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plan Sponsor may charge you for

the costs of providing the list. The Plan Sponsor will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions or limitation on your PHI** that the Plan Sponsor uses or discloses for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that is disclosed to someone who is involved in your care or the payment for your care, such as a family member or friend. Except as provided in the next paragraph, the Plan Sponsor is not required to agree to your request. However, the Plan Sponsor will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must make your request in writing to the Human Resources Department identified below. In your request, you must state (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse. If the Plan Sponsor honors the request, it will stay in place until you revoke it or the Plan Sponsor notifies you.
- **Right to Request Confidential Communications** about medical matters in a certain way or at a certain location. For example, you can ask that the Plan Sponsor only contact you at work or by mail. Your request must be made in writing to the Human Resources Department identified below and specify how or where you wish to be contacted. The Plan Sponsor will accommodate all reasonable requests.
- **Right to Be Notified of a Breach** in the event that the Plan Sponsor (or a Business Associate) discover a breach of unsecured PHI.
- **Right to a Paper Copy of This Notice.** You may request a paper copy of this notice at any time from the Human Resources Department identified below, even if you have agreed to receive this notice electronically

### Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact:

Natural Gas Services Group, Inc  
Human Resources Department/Privacy Officer  
508 W Wall, Suite 550  
Midland, TX 79701  
432-262-2700

All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Executed this 27 day of AUGUST, 2013

Company: NATURAL GAS SERVICES GROUP

By: LARRY AMADOR

Print Name: LARRY AMADOR

Title: HR Manager

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