Paychex Business Solutions LLC Health Flexible Spending Account
SUMMARY PLAN DESCRIPTION

Plans Originally Effective February 1, 1991

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Version 1.0 030124

TABLE OF CONTENTS

INTRODUCTION

Your worksite employer has adopted the Paychex Business Solutions LLC Health Flexible Spending Account (FSA) (the “Plan”) to allow you to make payments or reimbursements from your Health FSA or Limited Purpose Health FSA (your “Account”) for Qualifying Medical Expenses that you, your Spouse, or your Dependents incur and that are not otherwise paid for or payable by insurance. You will be able to contribute to the Plan using pre-tax compensation (before federal income taxes or social security taxes are withheld). As a result, you will pay less tax and have more money to spend and save.

The terms and conditions of the Plan are stated in this document (the “Summary Plan Description”) and the formal Plan Document. These documents constitute the written instruments under which the Plan is established and maintained. An amendment to one of these documents constitutes an amendment to the Plan.

Unless otherwise noted, if there is a conflict between a specific provision under the formal Plan Document and this Summary Plan Description or a document provided by the Claims Administrator, the formal Plan Document controls. If the formal Plan Document is silent, then this Summary Plan Description controls. If both the formal Plan Document and this Summary Plan Description are silent, the terms of the applicable formal benefits document control.

The Plan is maintained and administered by Paychex Business Solutions LLC (the “Company”). The Company reserves the right to change, amend, suspend, or terminate any or all the benefits under this Plan, in whole or in part, at any time for any reason at its sole discretion. Terms such as "Plan Administrator", "Coverage Period" and "Company" are used throughout the document and are defined in the Glossary.

ADMINISTRATIVE INFORMATION

Plan Name & Number	Paychex Business Solutions LLC Flexible Spending Account Plan (502)
Plan Sponsor	Paychex Business Solutions LLC 970 Lake Carillon Drive Suite 400 St. Petersburg, FL 33716 727-556-2812
Employer Identification Number	59-2693969
Plan Administrator	Paychex Business Solutions LLC 970 Lake Carillon Drive Suite 400 St. Petersburg, FL 33716 727-556-2812
Claims Administrator	Paychex Benefit Account (PBA) 225 Kenneth Drive Rochester, NY 14623 Claims for expenses should be submitted for adjudication and payment to: PBA online at www.paychexflex.com or through the PBA mobile application.
Agent for Service of Legal Process	General Counsel Paychex Business Solutions LLC 970 Lake Carillon Drive Suite 400 St. Petersburg, FL 33716 727-556-2812
Plan Year	January 1 – December 31
Administration & Funding	The benefits are self-funded and are administered by the Claims Administrator.
Source of Contributions	Contributions for the Plan are paid by employees through salary reduction elections.

GLOSSARY

Account	A bookkeeping account set up in your name to keep a record of your Health FSA contributions and the reimbursements to which you are entitled during the Coverage Period.
Affiliate	With respect to the Company, any corporation other than the Company that is a member of a controlled group of corporations, within the meaning of Section 414(b) of the Code, of which the Company is a member; all other trades or businesses (whether or not incorporated) under common control, within the meaning of Section 414(c) of the Code, with the Company; and any service organization other than the Company that is a member of an affiliated service group, within the meaning of Section 414(m) of the Code, of which the Company is a member; and any other entity required to be aggregated with the Company pursuant to Treasury regulations under Code section 414(o).
Claims Administrator	Paychex Benefit Account (PBA)
COBRA Administrator	Paychex COBRA Administration
Company	Paychex Business Solutions LLC
Coverage Period (also known as Plan Year)	The calendar year (January 1 – December 31)
Dependent Child	An individual may be a Dependent if he or she (i) is the child (includes step-child, eligible foster child or child placed for adoption) of the Employee and has not attained age 27 by the end of the relevant taxable year, (ii) meets the definition of a "qualifying relative," or (iii) is the descendant of a child of the Employee, a brother, sister, stepbrother, or stepsister of the Employee or a descendant of any such relative; has the same principal place of abode as the Employee for more than half the year; as of the end of the calendar year, is under age 19, or under age 24 if a full-time student (there is no age limit for a child who is permanently and totally disabled); does not provide more than half of his or her own support for the calendar year; and is a citizen or national of the United States or a resident of the U.S., Canada, or Mexico. The definition of a "qualifying relative" has three requirements: (1) relationship – the individual must be either (a) a child of the Employee (including a stepchild, foster child, or child placed with an Employee for adoption); (b) a descendant of a child; (c) a brother, sister, stepbrother, or stepsister of the Employee; (d) the father or mother of the Employee, or an ancestor of either the father or mother; (e) a stepfather or stepmother of the Employee; (f) a niece or nephew of the Employee; a brother or sister of the father or mother of the Employee; (h) a son-in law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the Employee; or (i) an individual, other than the spouse, who, for the taxable year, has the same principal place of abode as the Employee and is a member of the Employee's household. (2) support - the Employee must provide over half of the individual's support. (3) not anyone else's qualifying child - the individual cannot be anyone else's qualifying child. There are special rules for divorced or separated parents. In addition, special rules apply for dependents of dependents and named dependents filing joint returns. If you have any questions, please contact the Claims Administrator.
Employee	(1) Any person who performs services on behalf of an Employer and who is a common law Employee of such Employer, but shall not include an individual whose employment status has not been recognized by completion of Internal Revenue Service Form W-4 and who is not

	initially treated as a common law Employee of the Employer on the payroll records of the Employer; or (2) Any leased Employee of the Employer. For purposes of this paragraph, the term "leased Employee" means any person (other than an Employee of the Employer) who, pursuant to an agreement between the Employer and the "leasing organization" has performed services for the Employer (or for the Employer and one or more Affiliates) on a substantially full-time basis for at least one year and the individual's services are performed under the primary direction or control of such Employer.
Employer	Any entity that has contracted with the Company or its Affiliates for PEO services, and that has adopted this Plan with the consent of the Company.
ERISA	The Employee Retirement Income Security Act of 1974, as amended from time to time.
Flexible Benefits Plan	The Paychex Business Solutions LLC Flexible Spending Account Plan as it may be amended from time to time.
Highly Compensated Employee	An Employee who: (a) performs services for the Employer during the determination year; and (b) for the look-back year received compensation (as defined in Code section 415(c)(3), including elective deferrals as defined in Code section 402(g) and amounts excludible from salary under Code sections 125, 132(f)(4), or 457) in excess of $135,000 (for the 2022 look-back year), as adjusted to reflect cost-of-living increases; and (c) was a Participant of the top 20% of Employees during the look back year when ranked based on compensation received during the year. For purposes of this definition of Highly Compensated Employee, the "determination year" is the Plan Year, and the "look-back year" is the 12-month period immediately preceding the determination year.
Highly Compensated Individual	With respect to Code section 125, a Participant who is (a) an officer, (b) a Highly Compensated Employee, (c) a more-than-5 percent owner, or (d) a Spouse or Dependent of an individual described in (a), (b) or (c) above. With respect to Code section 105(h), Highly Compensated Individual means an individual who is (1) one of the five highest paid officers, (2) a more-than-10% owner of the employer's stock, or (3) among the highest paid 25% of all Employees.
HIPAA	The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.
Internal Revenue Code or Code	The Internal Revenue Code, as amended from time to time.
Key Employee	Any Employee of the Company who, at any time during the prior plan year, was (a) an officer with annual compensation for that plan year in excess of the applicable dollar threshold ($200,000 for 2022), (b) a more-than-5 percent owner of the Company, or (c) a more-than-1 percent owner of the Company with annual compensation in excess of $150,000.
Participant	Each Employee who participates in the Plan.
Plan	The Paychex Business Solutions LLC Flexible Spending Account Plan
Plan Document	The formal plan document that, along with this Summary Plan Description, constitutes the plan document for purposes of ERISA.
Plan Administrator	Paychex Business Solutions LLC
Plan Sponsor	Paychex Business Solutions LLC
Qualifying Medical Expenses	Expenses that are eligible to be reimbursed from the Plan, as described within Code section 213(d), or "menstrual care products" as defined in Code section 223(d)(2)(D).

Spouse	The individual to whom the Participant is lawfully married and is not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following are true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.
Summary Plan Description (SPD)	This booklet, which describes terms that apply to the benefits under the Plan and constitutes the Summary Plan Description that is required under ERISA.

ELIGIBILITY AND ENROLLMENT

Benefit Eligibility

You are eligible to participate in this Plan if the Plan has been adopted by your Employer and you are eligible to participate in a major medical plan offered by your Employer or the Company for the Coverage Period. To participate in this Plan, you must also complete the appropriate waiting period for your eligible benefit class. Additionally, for you to be covered, enrollment must be properly completed and timely received by the Company.

If you are enrolled in a high deductible health plan, accompanied by a Health Savings Account, you are not eligible to participate in a Health FSA, however you may participate in a Limited Purpose Health Flexible Spending Arrangement ("Limited Purpose Health FSA"). Under a Limited Purpose Health FSA, you may receive reimbursements for dental or vision care expenses or certain preventative care expenses the same way you would receive reimbursements if you participated in a Health FSA. If you elect to contribute to a Health Savings Account while you are participating in a Health FSA (including any Grace Period), your Health FSA will be converted to a Limited Purpose Health FSA.

Benefits Enrollment

It is important that you choose your benefits carefully and enroll timely. Your benefit elections remain in effect until the next plan year effective date (January 1st). You can only change your elections during the year if you experience a change in status event as defined below in the section “Changing Benefit Elections”.

- **New Employees:** As a new Employee you will be given the opportunity to enroll for benefits during your initial eligibility period. Your initial eligibility period is the period between when you become a benefit eligible Employee and your eligibility date. Your eligibility date is the 1st day of the month following your waiting period. Your waiting period is a period chosen by your employer that will not exceed 90 days. Coverage is not automatic in any benefits under the Plans. If you fail to enroll in coverage during your initial eligibility period, or within 30 days following your eligibility date, you will be deemed to have declined coverage and will have to wait until the next annual enrollment period to enroll for coverage.
- **Current Employees:** If you are a current Employee, you will have the opportunity to elect new coverage and/or change your current benefits elections each year during annual enrollment. Changes to benefits that you make during annual enrollment are effective on January 1st following the date you complete the enrollment process. If you fail to enroll or change elections during annual enrollment, your previous elections will carry over to the next plan year.
- **Rehired Employees:** If you are rehired by the same worksite Employer less than 30 days after the date your employment terminated, you will be reinstated with the same elections that you had before termination. If you are rehired more than 30 days after the date your employment terminated and are otherwise eligible to participate in the Plans, then you will need to satisfy the waiting period and make new elections; in other words, you will be treated as a new hire.

Termination of Benefit

You will cease to be a Participant in this benefit on the earlier of:

- the date on which the Plan terminates.
- the date on which you cease to be an Employee of the adopting worksite Employer.
- the date on which you fail to make the required contributions for coverage.
- the date on which you die.
- the date on which your worksite Employer rescinds its adoption of the Plan.
- the date on which the relationship between the Company (or one of its Affiliates) and your worksite Employer terminates.
- the date on which your election to receive benefits under this Plan expires or is terminated under the Flexible Benefits Plan.

Questions Regarding Eligibility, Enrollment, or Termination

If you have questions regarding whether you are eligible to participate in this Plan or how to enroll, please contact:

Paychex Benefit Account Services at 877-244-1771
Monday through Friday, from 8:00 am to 8:00 pm Eastern Time

CONTRIBUTIONS TO THE PLAN

How Do the Health FSA and Limited Purpose Health FSA Operate?

Before the start of each Coverage Period, you will be able to elect to have a portion of your compensation reduced and an amount equal to the reduction will be contributed to your Account. At the beginning of each plan year, the full amount of your elected Health FSA or Limited Purpose Health FSA amount for the entire year is available for your use, regardless of the actual balance in your account. The amount in your Account will be used to make payments or reimbursements for Qualifying Medical Expenses that you, your Spouse or your Dependents incur and that are not otherwise paid for or payable by insurance. The portion of your pay that is contributed to the Account is not subject to federal income or social security taxes. In other words, the Plan allows you to use tax-free dollars to pay for certain medical expenses not covered by insurance that you would normally pay for with after-tax dollars.

What is the Procedure for Contributing My Pay to My Health FSA or Limited Purpose Health FSA Account?

Prior to each Coverage Period you will be given the opportunity, pursuant to the procedures established by the Plan Administrator, to authorize a reduction in your compensation and to contribute that amount to an Account (up to a maximum reimbursement amount described in the “Benefits” section of this document). The amount you elect to have contributed to the Account is deducted from your compensation each pay period on a pro-rata basis over the course of the Coverage Period.

When Must I Decide the Amount of My Contribution to the Account?

At the time of your initial enrollment and before each Coverage Period begins, you will elect the amount by which your compensation will be reduced. Then, during each applicable pay period, the salary reduction contributions will be contributed to your Account. You must decide the amount to be contributed to your Account before the Coverage Period begins. This period during which you must make this decision about whether to contribute and, if so, how much, is called annual enrollment.

Can I Change My Contribution Election During the Coverage Period?

Unless you have a change in status event as shown below, you generally will not be able to change or terminate the amount you previously elected to contribute to the Account. During annual enrollment you will need to make your election during a specific election period that ends prior to the beginning of the next Coverage Period. You generally will not be able to change or terminate the amount you elect to contribute to the Account after that specific annual enrollment election period, unless you have a change in status event as shown below.

If you have a change in status event, any change in the amount you contribute must be consistent with the change in status event and you must notify the Paychex Health and Benefits Department 30 days or less

after the date of the change in status event. Failure to notify the Paychex Health and Benefits Department within 30 days after the date of the change in status event will result in you needing to wait until the next annual enrollment period to make the desired change to your benefit elections and then your new benefit elections will begin as of the next Coverage period.

The Plan Administrator may require such documentation as it deems necessary to substantiate your change in status event. The following are change in status events.

To request a change to your benefit elections due to a change in status event call the Paychex Health and Benefits Department at 800-741-6277, Monday through Friday, from 8:00 am to 8:00 pm Eastern Time.

	Actions Allowed			
Change in Status Event	**Enroll**	**Increase Contribution**	**Terminate Contributions**	**Decrease Contribution**
Change in your marital status				
You marry	Yes	Yes	No	No
You marry **and either** you and/or your Dependent become eligible under and enroll in your new Spouse's employer health plan, **or** your Spouse is enrolled in his or her employer's health FSA	No	No	Yes	Yes
You lose your Spouse through death, divorce, legal separation, or annulment	No	No	No	Yes
You lose your Spouse through death, divorce, legal separation or annulment, **and** you/your Dependents lose coverage under your Spouse's employer's health plan or health FSA.	Yes	Yes	No	No
Gain or loss of a Dependent Child				
You gain a Dependent Child (for example, through birth, adoption)	Yes	Yes	No	No
You lose a Dependent Child or a Dependent Child loses eligibility (for example, through death, or when an individual is no longer financially supported by you, or your child no longer satisfies the age requirements for health coverage)	No	No	Yes	Yes
Change in employment status				
You, your Spouse or Dependent Child gains eligibility for and enrolls themselves and/or you in their employer's health FSA, **because** you/he/she starts employment or has an employment status change.	No	No	Yes	Yes
Your Spouse or Dependent Child loses eligibility for own employer's health FSA or health plan **because** you/he/she ends employment or has an employment status change.	Yes	Yes	No	No
Certain judgments, decrees, and orders				
If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your	Yes	Yes	Yes	Yes

Change in Status Event	Actions Allowed			
	Enroll	Increase Contribution	Terminate Contributions	Decrease Contribution
dependent) to be covered under the health 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 if such coverage is, in fact, provided for that child.				

Modifications To Elections as Required by the Plan Administrator

The Plan Administrator may modify your election(s) downward during the Coverage Period if you are a Key Employee or Highly Compensated Individual and it is necessary to prevent the Flexible Benefits 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 Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

Can I Make New Elections in Future Coverage Periods?

For each new Coverage Period, you will be given the opportunity during an annual enrollment period to change the amount you previously elected to contribute to the Account. You may also choose to have none of your compensation contributed to the Account for the upcoming Coverage Period.

To participate in the Plan for the next Coverage Period, you must make an election during the annual enrollment period. If you previously elected to participate in the Plan for a Coverage Period and fail to make any election regarding the Plan during the annual enrollment period, you will be deemed not to have elected to continue to participate in the Plan. In this event, your compensation will not be reduced and contributed to an Account during the next Coverage Period.

BENEFITS

What is the Maximum Health FSA Contribution I Can Elect?

You can elect to contribute an amount to be used to reimburse you for certain covered health care expenses subject to a maximum amount per Coverage Period. For 2023 the most you can contribute is $3,050. The annual limit may change from year to year as specified by the IRS. If you begin to contribute in any month other than January the maximum amount you can contribute will be pro-rated based on the in-force maximum and the number of months remaining in the year.

If you are enrolled in a high deductible health plan, accompanied by a Health Savings Account, you are not eligible to participate in a Health FSA. However, you may participate in a Limited Purpose Health Flexible Spending Arrangement ("Limited Purpose Health FSA"). Under a Limited Purpose Health FSA, you may receive reimbursements for dental or vision care expenses or certain preventative care expenses the same way you would receive reimbursements if you participated in a Health FSA. Also, if you elect to contribute to a Health Savings Account while you are participating in a Health FSA (including any Grace Period), your Health FSA will be converted to a Limited Purpose Health FSA.

What Are the Covered Expenses under a Health FSA?

Covered expenses are Qualifying Medical Expenses incurred by you, your Spouse or your Dependent Child for “medical care” within the meaning of Code section 213(d), or “menstrual care products” as defined in Code section 223(d)(2)(D), but only to the extent that you, your Spouse or your Dependents that incur the expense are not reimbursed for the expense through insurance or otherwise other than under this Plan. Qualifying Medical Expenses do not include premium payments for other medical plan coverage, including premiums paid for medical coverage under a plan maintained by the employer of a Spouse or Dependent.

Examples of Qualifying Medical Expenses are:

- Deductibles and co-payments under any medical, vision or dental plan sponsored by the Company or under other accident and health insurance.
- Dental care, including routine dental checkups, orthodontic work, and dentures.
- Medicine and drugs, including over-the-counter medicines or drugs (e.g., pain reliever, antacid, allergy medicine, cold medicine, or insulin).
- Eye care, including vision checkups, eyeglasses, and contact lenses.
- Hearing care, including hearing examinations and hearing aids.
- Routine physical examinations.
- Menstrual care products (e.g., a tampon, pad, liner, cup, sponge, or similar product).

If you receive reimbursement under the Plan, and reimbursement for the same expense is made under another plan, you are required to refund the reimbursement made under this Plan to the Company. The amount of your elected coverage under the Plan, to the extent of any such refund, will be reinstated for the Plan Year in which the reimbursement was originally made.

What Happens If I Don’t Spend the Entire Amount in My Account?

The amount contributed to your Account for any Coverage Period shall be used only to reimburse (or make payment) for qualifying expenses incurred during the Coverage Period. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

Claims, including required supporting documentation, for expenses incurred during the Coverage Period must be submitted to the Claims Administrator by the 90th day following the close of the Coverage Period to be considered for reimbursement from amounts remaining in your Account at the end of the coverage period. You will be eligible to carryover amounts left in your Account up to $550. This means that amounts you do not use during a Coverage Period will carry over to the next Plan Year and may be used for eligible expenses incurred in the next Plan Year. You can only use carryover amounts within the next Plan Year. Any amount contributed to your Account that is not used during the coverage period to reimburse (or pay) for expenses and that exceeds the carryover limit of $550, if any, will be forfeited.

How Do Leaves of Absence Affect My Health FSA Benefits?

During a leave of absence that is approved under the Family and Medical Leave Act (FMLA), you may revoke or change your existing elections for the Account. If you choose to continue your contributions, then you may pay your share of the contributions in one of the following three ways:

1. with after-tax dollars while on leave of absence.
2. 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 pre-payments with pre-tax dollars may not be used to pay for coverage during the next Coverage Period), or
3. 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 you terminate further contributions to your Account during an FMLA leave, you can reinstate contributions for the remaining part of the Coverage Period upon your return. Contributions can be reinstated at the pre-

leave level (i.e., the same pre-tax deduction amount will be taken from your paycheck as was being taken before you went on leave), or at a higher level to make up for the contributions that you missed while you were on leave.

During a non-FMLA leave of absence, your contributions will cease on the last day that you work, and you will be offered COBRA. Upon return from a non-FMLA leave, you will be treated as a rehire which means, if you are rehired by the same worksite Employer less than 30 days after the date your employment terminated, you will be reinstated with the same elections that you had before termination. If you are rehired more than 30 days after the date your employment terminated and are otherwise eligible to participate in the Plan, then you will need to satisfy the waiting period and make a new election. If you are actively enrolled in COBRA for Health FSA coverage upon your return to active status, you will need to terminate your COBRA coverage by notifying the COBRA Administrator in writing before your benefits can be re-instated as an active Employee.

Will I Be Taxed on the Health FSA Benefits I Receive?

Reimbursements to you from your Health FSA for eligible expenses should not be taxed. However, there may be tax consequences if you request and receive reimbursement for expenses that do not meet the definition of "medical care" or “menstrual care products” as defined in the Code. If you are reimbursed for a claim that is later determined to not be for medical care expenses or menstrual care products, then you will be required to repay the amount and there may be tax consequences. Generally, you will not be taxed on your benefits. However, the Company cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits you receive depend on the validity of the claims you submit. For example, to qualify for tax-free treatment, your medical care expenses must meet the definition of a Qualified Medical Expense.

It is your responsibility to determine whether any reimbursement under the Plan constitutes medical care expenses that qualify for the federal income tax exclusion. Ask the Claims Administrator if you have questions but remember that the Claims Administrator is not providing legal advice.

What Happens If I Fail to Cash a Check for Benefits?

If a check to you for benefits under the Plan remains uncashed beyond the “void” date listed on the check, or, if no “void” date is listed, for 180 days after issue, the amount attributable to that check shall be forfeited by you to the Plan and you will have no further claim to that amount for any reason.

Limited Purpose Health FSA

If you are enrolled in a high deductible health plan, accompanied by a Health Savings Account, you may only enroll in a Limited Purpose Health FSA. The above rules apply, except that Qualifying Medical Expenses are limited to:

- Vision and dental care expenses; or
- Preventive care benefits as described in IRS Notice 2004-23 and other applicable IRS guidance.

CLAIMS PROCEDURES

How Do I File a Claim for Reimbursement?

You will receive specific instructions on how to file a claim for reimbursement of Qualifying Medical Expenses incurred by you, your Spouse, or your Dependent Children during the Coverage Period from the Claims Administrator. The Claims Administrator may require certain information such as:

- the amount, date, and nature of the expense,
- the service provider;
- a written statement from an independent third party stating that the expense has been incurred; the name of the person for whom the expense was incurred and the relationship of such person to you;

and a statement that the expense (or the portion of the expense for which reimbursement is sought) has not been reimbursed and is not reimbursable under any other health plan coverage.

The Claims Administrator will provide you with a debit card to use to pay for Qualifying Medical Expenses and further details and instructions on the use of the debit card.

What Is the Deadline to File a Claim for Reimbursement?

You must file a complete claim for reimbursement on or before the 90th day following the close of a Coverage Period to be reimbursed for expenses incurred during such Coverage Period.

What Happens If I Cease Participation in the Health FSA or Limited Purpose Health FSA During the Year?

If you cease participation in the Plan during the Coverage Period, you only will be entitled to reimbursement for Qualifying Medical Expenses incurred prior to the date you cease to participate, and you must apply for reimbursement on or before the 90th day following the date you cease to participate in the Plan. To receive reimbursement for Qualifying Medical Expenses incurred after the date you cease to participate, you may be able to elect to continue participation under the COBRA rules described in Continuation of Coverage section of this document.

What is the Claims Review Procedure Under the Health FSA and Limited Purpose Health FSA?

All general claims or requests should be directed to the Claims Administrator. The Claims Administrator, designated by the Plan Administrator and the Plan Administrator, will have absolute discretion to construe and interpret all provisions of the Plan. If your claim is wholly or partially denied, the Claims Administrator will notify you of its decision in writing. Such notification will be given within a reasonable period, but no later than thirty (30) days after the claim is received by the Plan Administrator, or forty-five (45) days if special circumstances beyond the control of the Plan require an extension of time for processing the claim and if written notice and the circumstances of such extension are given to you within the initial 30-day period. Such notification will be written in a manner calculated to be understood by you and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions, (iii) a description of any additional material or information necessary for you to perfect such claim and an explanation of why such material or information is necessary, (iv) describe the Plan's claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review, (v) disclose any internal rule, guideline, or protocol relied on in making the adverse determination (or state that such information is available free of charge upon request), and (vi) if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

You have 180 days after your claim is denied to ask the Plan Administrator for a review of your claim. During this 180-day period, you have the right to look at all relevant documents and to give your views and comments in writing. You will be notified of the Plan Administrator’s benefit determination on review within a reasonable time, but not later than 45 days from receipt of the request for review. If the Plan Administrator determines that an extension is necessary due to special circumstances, this time may be extended for an additional 45 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Plan Administrator then will make its determination within 45 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information. The Plan Administrator must make a decision within 60 days after it receives your request for review. The decision of the Plan Administrator must be given to you in writing and must (i) state specific reason(s) for the adverse determination; (ii) reference specific Plan provision(s) on which the benefit determination is based; (iii) state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; (iv) describe any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; (v) disclose any internal rule, guidelines, or protocol relied on in making

the adverse determination (or state that such information will be provided free of charge upon request); (vi) if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and (vii) include a statement regarding your right to bring an action under section 502(a) of ERISA.

You, or any other person claiming a benefit under the Plan, must follow the applicable claims procedures before taking action in any other forum regarding a claim for benefits under the Plan. Any suit or legal action initiated under the Plan must be brought no later than one year following a final decision on the claim for benefits under these claim procedures. If a civil action is not filed within this period, the asserted benefit claim is deemed permanently waived and abandoned.

LEGAL NOTICES

COBRA Continuation of Coverage Rights

Introduction

If required by law, the Plan will provide a notice of your COBRA continuation of coverage rights. COBRA continuation of coverage is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. The COBRA Administrator listed below is responsible for administering COBRA continuation coverage. Contact the COBRA Administrator with any questions you have about COBRA.

Paychex Business Solutions
Attn: COBRA Department
225 Kenneth Drive
Rochester, NY 14623
Phone: 877-244-1771

COBRA Qualified Beneficiaries and COBRA Qualifying Events

If you are an Employee, you will become a COBRA qualified beneficiary if you lose your Health FSA or Limited Purpose Health FSA coverage because one of the following qualifying events happens:

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

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your Health FSA or Limited Purpose Health FSA under the Plan because one of the following qualifying events happens:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent Child(ren) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies.
- The parent-Employee's hours of employment are reduced.
- The parent-Employee's employment ends for any reason other than his or her gross misconduct.
- The parent-Employee becomes enrolled in Medicare (Part A, Part B, or both)

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a Dependent.

COBRA Notice of Qualifying Event Procedures

Any notice of a qualifying even must be sent in writing to the Plans along with supporting documentation of the qualifying event:

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Attn: COBRA Department
225 Kenneth Drive
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Phone: 877-244-1771

Oral notice, including notice by telephone, is not acceptable. Any written notice must state the name of the Plan, the name and address of the Employee covered under the Plan and the names and addresses of the qualified beneficiaries covered under the Plan. Your notice must also name the COBRA qualifying event and the date it occurred and include all supporting documentation. Any written notice or election sent to the COBRA Administrator must be received by the applicable due date. A notice or election sent to the COBRA Administrator will be considered timely if postmarked by the applicable due date and received by the COBRA Administrator.

Offer of COBRA Continuation Coverage

COBRA continuation coverage is provided subject to your eligibility for coverage. Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries who have underspent accounts. For each qualified beneficiary with an underspent account who elects continuation coverage on a timely basis, continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period, the right to elect continuation coverage will be lost.

Early Termination of COBRA Continuation Coverage

COBRA continuation coverage may be terminated prior to the exhaustion of the foregoing time periods in the event of any of the following:

- The Company stops offering a Health FSA or Limited Purpose Health FSA to all Employees.
- The qualified beneficiary fails to timely pay the required premium.
- After electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the individual.
- After electing COBRA coverage, a qualified beneficiary becomes enrolled in Medicare (Part A, Part B, or both).

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period

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

Alternate Recipients Under QMCSO

A child of the covered Employee who is receiving benefits under the Plans pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered Employee's period

of employment with the employer is entitled to the same rights under COBRA as a dependent child of the covered Employee, regardless of whether that child would otherwise be considered a dependent.

Frequently Asked Questions about COBRA:

When is COBRA Continuation Coverage Available?

The Plans will offer COBRA continuation coverage to qualified beneficiaries (with underspent accounts) only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee or enrollment of the Employee in Medicare (Part A, Part B, or both*), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For all other qualifying events (divorce or dependent child losing eligibility as a dependent child), you must notify the Plan Administrator in writing. You are required to follow the procedures set forth in the paragraph entitled "Notice Procedures," below. The Plans require you to notify the Plan Administrator within 30 days after the qualifying event occurs.

*It is not considered a qualifying event if you voluntarily terminate coverage following Medicare enrollment and your spouse and/or dependents lose coverage under the Plan as a result.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a COBRA qualifying event. Specific COBRA qualifying events are listed later in this notice. After a COBRA qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" (and has an underspent account). You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plans is lost because of the qualifying event. Under the Plans, qualified beneficiaries who elect continuation coverage must pay for continuation coverage. Failure to make timely payments will result in the termination of continuation coverage. Once a qualified beneficiary loses coverage for nonpayment, coverage cannot be reinstated. Payments will be timely if received and postmarked by the COBRA Administrator by the due date.

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by reimbursable claims submitted up to the time of the qualifying event).

How is COBRA Continuation Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries who have underspent accounts. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. For those qualified beneficiaries losing coverage who have underspent accounts, COBRA coverage under the Health FSA or Limited Purpose Health FSA lasts for the remainder of the calendar year in which you became eligible for continuation coverage. (Although you would not be able to make contributions on a pre-tax basis, by electing continuation of coverage for this account, you would still have the opportunity to file claims for reimbursement based on your account balance for the year.)

In addition, the Plan allows you to carryover up to $550 of any amount remaining in your Health FSA or Limited Purpose Health FSA as of the end of the calendar year in which you became eligible for continuation of coverage. Such carryover amount may be used to pay or reimburse medical expenses incurred during

the maximum duration of the COBRA continuation period (described below) (i.e., 18, 29, or 36 months). Any unused amount of more than $550 remaining in your Health FSA or Limited Purpose Health FSA at the end of the calendar year in which you became eligible for continuation of coverage will be forfeited.

The following rules apply to any $550 carryover remaining in your Health FSA or Limited Purpose Health FSA at the end of the calendar year in which you became eligible for continuation of coverage:

- When the qualifying event is death of the Employee, enrollment of the Employee in Medicare (Part A, Part B, or both), your divorce or legal separation or a dependent child losing eligibility as a dependent child, continuation coverage lasts for up to 36 months. The following sets forth the requirements under COBRA. Some states may require an additional period of continuation of coverage. You will be notified if these state continuation rules apply to you at the time you become eligible for COBRA or the state continuation coverage. If you have questions regarding this provision, please contact the Oasis COBRA Department.
- When the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period of continuation coverage can be extended:

1. **Disability extension of 18-month period of continuation coverage.** If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of continuation coverage, for a total maximum of 29 months. You must make sure the Plan Administrator is notified in writing of the SSA's determination within 60 days after the date of the determination and before the end of the 18-month period of continuation coverage. You are required to follow the procedures specified above in the paragraph titled "Notice Procedures" on the previous page. In addition, your notice must include the name of the disabled qualified beneficiary, the date that the qualified beneficiary became disabled, and the date that the SSA made its determination. Your notice must also include a copy of the SSA's determination. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required period, there will be no disability extension of continuation coverage.
2. **Second qualifying event extension of 18-month period of continuation coverage.** If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can receive additional months of continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former Employee dies or gets divorced. This extension is also available if the former Employee loses coverage because of enrolling in Medicare Part A, Part B, or both. The extension is also available to a dependent child when that child stops being eligible under the plan as a dependent child. In all these cases, you must make sure that the Plan Administrator is notified in writing of the second qualifying event within 30 days of the second qualifying event. You are required to follow the procedures specified above in the section entitled "Notice Procedures." Your notice must also name the second qualifying event and the date it occurred. If the second qualifying event is a divorce, your notice must also include a copy of the divorce decree. If these procedures are not followed, or if the notice is not provided in writing to the Plan Administrator within the required 30-day period, there will be no extension of continuation coverage due to a second qualifying event.
3. **Medicare extension for spouse and dependent children.** If a qualifying event that is a termination of employment or a reduction of hours occurs within 18 months after the covered Employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end 3 years from the date the Employee became entitled to Medicare (but the covered Employee's maximum coverage period will end at 18 months following the termination of employment or reduction of hours).

If You Have Additional Questions Concerning COBRA

For more information about your rights COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa . (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit https://www.HealthCare.gov.

Keep your plan administrator informed of address changes to protect your family's COBRA rights, you should keep the Plan Administrator informed of any changes to your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

ERISA Rights Statement

The following statement is required by federal law and regulations concerning your rights under the Plan: As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- Obtain, upon written request to the Plan 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.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan because 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.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court after exhausting the claims procedures set forth in this Summary Plan Description. If the 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 suite 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. It may do so, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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 Ave. 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.

Qualified Medical Child Support Order

A medical child support order is a judgment, decree, or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

HIPAA

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the benefits manager.

This Plan, and the Plan Sponsor, will not use or further disclose protected health information (PHI) that is protected by HIPAA except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan requires all its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information.

You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Contact the Plan's Privacy Officer by email at Privacy_Office@paychex.com.

The Plan Sponsor will:

- Not use or further disclose PHI other than as permitted or required by the Plan Document or by law.
- Ensure that any agents, including subcontractors that receive PHI from the group health plan agree to the same HIPAA restrictions and conditions.
- Not use or disclose PHI for employment-related actions and decisions.
- Not use or disclose PHI in connection with any other benefit or employee benefit plan; report to the group health plan any known PHI uses or disclosures that are inconsistent with those specified in the plan document.
- Make PHI available to an individual based on HIPAA's access requirements.
- Make PHI available for amendment and incorporate any PHI amendments.
- Make available the information required to provide an accounting of disclosures.

If you have questions regarding Health FSA claims or enrollment contact:
Paychex Benefit Account (PBA) Services at 877-244-1771
Monday-Friday, from 8:00 am to 8:00 pm Eastern Time
or by email at PaychexBenefitAccount@Paychex.com