

FLEXIBLE SPENDING ACCOUNTS PLAN

The Flexible Spending Accounts Plan consists of two accounts, the Health Care Reimbursement Account and the Dependent Day Care Reimbursement Account, which allow you to pay for a variety of health care and dependent day care expenses on a before-tax basis. By paying for expenses on a before-tax basis, you reduce your income for the purpose of state, federal and Social Security taxes. Enrollment in the Flexible Spending Accounts Plan is optional.

WHO IS ELIGIBLE FOR THE FLEXIBLE SPENDING ACCOUNTS PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible to participate in the Flexible Spending Accounts Plan on the first day of active employment.

Participation in the Dependent Day Care Reimbursement Account also requires that you are:

- a single parent and require dependent day care so you can work, or
- married and require day care so you can work and your spouse can work or be a full-time student.

ENROLLMENT

Eligible employees may enroll in the Health Care and/or Dependent Day Care Reimbursement Accounts within 30 days of their date of hire. Once you enroll, you must continue participation in the plan until the end of the calendar year. If you do not enroll for coverage within 30 days of your date of hire, you will be required to wait until the next Open Enrollment Period or when you have a Qualifying Event to elect coverage.

To enroll, you must complete an enrollment form and indicate the amount you want to contribute to the Health Care and/or Dependent Day Care Reimbursement Accounts. Enrollment forms are available through the Benefits Office. By completing the form, you will authorize an annual salary reduction amount. Your actual contributions will be made from your paycheck in equal monthly or weekly installments depending on your pay status.

Coverage begins on your date of hire if you complete the enrollment form and submit it to the Benefits Office within 30 days of your date of hire.

Enrollments completed during an Open Enrollment Period will be effective on January 1 of the following calendar year.

HEALTH CARE REIMBURSEMENT ACCOUNT

Benefits Provided

You can use the Health Care Reimbursement Account to reimburse yourself for eligible health care expenses with before-tax dollars. You determine what types of expenses you expect to have during the plan year and fund your Health Care Reimbursement Account through automatic salary reduction. You

draw money out of your Account to reimburse yourself for the health care expenses as you and your eligible dependents incur them.

Your eligible dependents include:

- Your spouse.
- Your unmarried children up through the end of the calendar year of attainment of age 18.
- Your unmarried children who are full-time students at an accredited college or university up through the end of the year of attainment of age 23.
- Your unmarried children who are mentally or physically incapable of earning their own living.

What Health Care Expenses are Reimbursed?

Expenses that are reimbursable under the Health Care Reimbursement Account are mainly those goods and services currently allowed by the Internal Revenue Service (IRS) as an income tax deduction, but not all items that qualify for a tax deduction also qualify for the Reimbursement Account. However, this does not include premiums paid for insurance coverages. Eligible expenses include, but are not limited to:

- Deductibles and co-insurance payments that are not reimbursed under the medical or dental insurance plans.
- Out-of-pocket expenses.
- Charges not reimbursed by the medical or dental insurance plans that are above reasonable and customary charges.
- Hearing and vision care expenses such as exams, eyeglasses, and contact lenses.
- Annual physical examinations.
- Approved weight-loss and stop-smoking programs, if prescribed by a physician to treat a specific condition.
- Over-the-counter medications used to alleviate or treat personal illness or injuries. Dietary supplements to maintain one's health (such as vitamins) do not qualify for reimbursement.

How Much May You Contribute Each Year to the Health Care Reimbursement Account?

You may contribute any amount from a minimum of \$300 to a maximum of \$3,500 each calendar year.

It is extremely important that you carefully determine the amount you elect to contribute, if any, since under IRS regulations, all amounts that you do not use toward expenses incurred in the calendar year will be forfeited.

DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT

Benefits Provided

You can use the Dependent Day Care Reimbursement Account to reimburse yourself for eligible dependent day care expenses with before-tax dollars. Estimate the amount you will be spending in the coming year on day care. Then, to cover these costs, you contribute to the Account through automatic salary reduction. Throughout the year, you draw money out of your Account and reimburse yourself for payments you have made to your day care provider.

What Dependent Day Care Expenses are Reimbursed?

Expenses that are reimbursable under the Dependent Day Care Reimbursement Account are mainly

those currently allowed by the IRS as a tax credit, but not all items that qualify for a tax credit also qualify for the Reimbursement Account. All day care must be rendered by eligible providers. Eligible expenses include, but are not limited to:

- Care of a dependent in your home by a paid provider.
- Care of a dependent outside of your home by a licensed nursery or day care center.
- Household services, such as a housekeeper, provided some portion of the service is to a dependent.

A relative is considered an eligible provider of dependent day care if he or she is not claimed as your dependent for tax purposes. The provider's name, address and Tax Identification Number or Social Security Number must be supplied to receive reimbursement.

Who are Eligible Dependents?

Expenses may be claimed for:

- A child under age 13 who is claimed as a dependent on your income tax return.
- Any dependent you claim for income tax purposes who requires day care because of physical or mental inability.

How Much May You Contribute Each Year to the Dependent Day Care Reimbursement Account?

You may contribute any amount from a minimum of \$300 to a maximum of \$5,000. However, there are certain guidelines you must follow. If you are single or if you are married and file separate income tax returns, the maximum amount you may contribute is \$2,500 in a calendar year. Your total contribution in any calendar year may not exceed your annual earnings or, if less, your spouse's annual earnings.

It is extremely important that you carefully determine the amount you elect to contribute, if any, since under IRS regulations, all amounts you do not use toward expenses incurred in the calendar year will be forfeited.

Dependent Day Care Reimbursement Account or Tax Credit

Federal law currently permits an individual to take a tax credit against federal income taxes for allowable dependent care expenses. When considering contributions to the Dependent Day Care Reimbursement Account, you may want to consider if it is better to take the tax credit or to pay for your dependent care expenses through the Flexible Spending Account.

With the dependent care tax credit, you pay your dependent day care expenses yourself and claim a credit for them on your federal income tax return.

You may use only one of these methods for any given dollar of dependent care costs. You cannot use the Dependent Day Care Reimbursement Account for a particular expense and also claim a credit for that same expense on your tax return.

You should consult your tax advisor to determine whether it is better for you to reimburse yourself for day care expenses with the Dependent Day Care Reimbursement Account or use the tax credit on your income tax return.

Does the Use of Before-Tax Contributions to the Flexible Spending Accounts Plan Affect Any Other Benefits?

It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced, but only minimally.

CLAIMS

How to File a Claim

To file a claim, you must complete a Reimbursement Account Request Form, available in the Benefits Office or through the Benefits Office website at www.bnl.gov/hr/benefits/.

For Dependent Day Care expense claims, you will need to provide the name, address, and Tax Identification Number or Social Security Number of your day care provider.

For Health Care expense claims, you must first submit your medical and dental claims to the applicable insurance company. You will receive your Explanation of Benefits (EOB) from the insurance company. If you are not enrolled in the medical or dental plans or are enrolled in an HMO, you must provide itemized bills.

When you have gathered the EOB and/or itemized bills, complete the Health Care or Dependent Day Care Request Form, attach the necessary information, and mail it to the address on the form.

Checks will be issued monthly for eligible health care and dependent day care expenses. If your claims do not total at least \$50, they will be held until additional claims are submitted unless it is the final reimbursement of the plan year.

How Long Do You Have to Submit Claims for Reimbursement?

You have until March 31 following the calendar year in which you incurred expenses to submit claims for reimbursement. So, for example, if you buy eyeglasses in December, you would still have up to March 31 to claim the expense, provided there is money remaining in your Health Care Reimbursement Account.

Questions About Claims

If you have a question about your Flexible Spending Account claim, you should contact CIGNA at (800) 242-2269.

How to Appeal a Claim

If your claim is denied, you will receive a written notice of the denial from the insurance company. The notice will explain the reason for the denial and indicate the review procedures. You may request a review of the denied claim. The request must be submitted in writing to CIGNA Reimbursement Accounts, P.O. Box 5200, Scranton, PA 18505 within 60 days after you receive the denial notice. Submit your request, including your reasons for requesting the review and any additional documents which you believe support your claim. CIGNA will review the claim and ordinarily notify you within 60 days of the date your request for review is received. In special cases requiring a delay, CIGNA will render a decision no later than 120 days after your request for review is received.

CHANGES IN CONTRIBUTION AMOUNTS

The amount of pre-tax dollars you elect to contribute to your Health Care or Dependent Day Care Reimbursement Account is irrevocable and thus, will remain in effect for the entire calendar year. You may be eligible to change your contribution only if you have a Qualifying Event.

OPEN ENROLLMENT PERIOD

Open enrollment is held once a year. During an Open Enrollment Period, you may elect your contribution amount for the following calendar year. Your election during the Open Enrollment Period will be effective January 1 of the following calendar year. Coverage will not automatically carry forward from year to year. You must elect coverage during the Open Enrollment Period for the following calendar year. Your elections will be in effect for the remainder of the calendar year unless you notify the Benefits Office of a Qualifying Event within 31 days of the event.

QUALIFYING EVENT

A Qualifying Event is a change in your family status and includes:

- a) Change in legal marital status
 1. marriage
 2. death of spouse
 3. divorce
 4. legal separation
 5. annulment
- b) Change in the number of dependents
 1. birth
 2. adoption
 3. placement for adoption
 4. death of a dependent
- c) Change in employment status
 1. termination or commencement of employment of the employee, spouse or dependent (other than for misconduct)
- d) Changes in work schedule
 1. an increase or decrease in the number of hours of employment by the employee, spouse or dependent
 2. a switch between full-time and part-time status
 3. a strike or lockout
 4. commencement or return from an unpaid leave of absence
- e) The dependent satisfies or ceases to satisfy the requirements for unmarried dependents
 1. attainment of age
 2. student status
- f) A change in the place of residence or work site of the employee, spouse or dependent

You have 31 days from the date of a Qualifying Event to make changes to your FSA coverage for all items indicated above except (a)(3), (a)(4), (e)(1) and (e)(2). You have 60 days from the date of a Qualifying Event to make changes to your FSA coverage for items (a)(3), (a)(4), (e)(1) and (e)(2). The change requested must relate to the change in your family status that affects eligibility for Flexible Spending Account coverage. Changes are made by completing an enrollment form, available through the Benefits Office. The completed form must be submitted, with proof of the Qualifying Event, to the Benefits Office. Your contributions will then be changed for the remainder of the calendar year. Coverage will become effective as of the date of the event.

If you do not make a change to your contributions within the applicable period indicated above, you must wait until the next Open Enrollment Period.

MISCELLANEOUS

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, and modification, suspension, or termination of the plan can be found in the General Information section of this booklet.

Leave of Absence

If you are on an approved Leave of Absence, you may continue your Flexible Spending Accounts coverage by paying your elected contributions for the remainder of the calendar year. If you discontinue contributions, only expenses incurred prior to the leave will be eligible for reimbursement. If you discontinued contributions at the time of your leave, upon return to work, you may elect to participate for the remainder of the calendar year by completing an enrollment form.

Restrictions

Flexible Spending Accounts are allowable under Section 125 of the Internal Revenue Code, and certain restrictions apply to them.

- Determination of your annual contributions to your Flexible Spending Account(s) must be made prior to the start of the plan year.
- To be eligible for reimbursement, expenses must be incurred in the same year that your salary reductions are credited to the Plan.
- Health care expenses cannot be reimbursed from a Dependent Day Care Reimbursement Account, nor dependent day care expenses from a Health Care Reimbursement Account.
- All unused Account balances remaining at the end of a plan year are forfeited.
- Expenses reimbursed from your Account(s) cannot be claimed as deductions or credits on your federal income tax return.
- Re-enrollment is required each year to have your before-tax contributions made to the Flexible Spending Accounts Plan.
- The IRS considers the two Flexible Spending Accounts totally separate and thus, does not allow you to transfer money from one account to the other.

Termination of Coverage

Flexible Spending Accounts Plan benefits will cease on the earlier of the date your employment terminates or the date you are no longer eligible for coverage. You may not continue your Dependent Day Care Reimbursement Account but you may continue your Health Care Reimbursement Account. Health Care Reimbursement Account coverage for terminated employees, who continue benefits under COBRA, will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

COBRA

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- Your hours of employment are reduced, or
- 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 coverage under the Plan because any 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 entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children 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 entitled to Medicare benefits (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 child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Benefits Office 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, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Benefits Office of the qualifying event.

Notification Requirements

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Benefits Office in writing within 60 days after the qualifying event occurs and provide documentation of the event.

When the Benefits Office has been notified that one of these events has occurred, they will in turn notify you and your dependents of the right to elect continuation coverage.

If you do not elect continuation coverage within 60 days from the date of loss of coverage due to one of the events described above, your group health insurance coverage will end retroactively to the date of the event that caused the loss of coverage.

If you elect continuation coverage, you will have the health insurance coverage you had before the event, although it may be modified if coverage changes for similarly situated participants.

How is COBRA Coverage Provided?

Once the Benefits Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part

B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Benefits Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the Benefits Office within 60 days after the qualifying event occurs and provide documentation of the event.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

COBRA Premium Requirements

You, or your dependents, will be required to pay 102% of the full cost of the continuation coverage under the provisions of COBRA. You will be billed for the required premium on a regular basis. COBRA premiums are indicated at the end of the Dental Plan section.

Termination of Coverage Under COBRA

Continuation coverage will end when any of the following events occur:

- The Benefits Office is notified by you or your dependent to discontinue coverage.
- 18 months after continuation coverage begins (if coverage was continued due to termination or resignation of the employee).
- 29 months after continuation coverage begins (if coverage was continued due to disability).
- 36 months after continuation coverage begins (if coverage was continued because of death of the employee, divorce, legal separation or loss of dependent status).
- The individual becomes eligible for Medicare after the date of the COBRA election.
- An individual becomes covered under another group plan, unless a pre-existing condition prevents you or your dependent from being covered by the other plan.
- For a spouse or dependent child: If the Benefits Office is not notified within 31 days of the

- date of divorce or legal separation.
- For a dependent child: If the Benefits Office is not notified within 31 days of the date the dependent status ends.
 - Payment for continuation coverage is not paid on time.
 - The group health care plan is terminated for active employees.

