CITY OF LA CROSSE

SECTION 125 CAFETERIA PLAN

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SUMMARY OF BENEFITS

BENEFITS AVAILABLE:

Premium for Group Coverage You may elect to have the portion of insurance premium You pay, if any, towards any of Your Employer's eligible group plans deducted pre-tax from Your payroll. You must meet the eligibility requirements of the group plan to qualify for this benefit. You will be automatically enrolled for pre-tax premium deductions.
Flexible Spending for Reimbursement of Healthcare Expenses You may elect to set aside pre-tax dollars from Your payroll to cover healthcare expenses that would otherwise not be reimbursed. You can use these dollars for deductible amounts, certain services that are not covered by Your health plan and dental and vision expenses. The maximum you can set aside each year is $2,550.
Dependent Care Reimbursement You may elect to set aside pre-tax dollars from Your payroll to pay for dependent care while You are working. For married individuals, Your spouse must also be working or going to school to be eligible for this benefit. The maximum amount You can set aside is $5,000 for married couples who file income tax jointly or $2,500 when filing separate tax returns. There are other provisions that may apply. Please refer to Section III of the plan document for more details.

REQUIREMENTS TO QUALIFY FOR BENEFITS UNDER THE FLEXIBLE SPENDING PLAN:

Eligibility To qualify for participation, You must be one of the following: full-time Employee;, permanent part-time Employee under a collective bargaining agreement or Terms & Conditions of employment; or an elected official. You may begin participation on the first of the month following 60 days of qualifying employment.
Procedures You will be automatically enrolled in the Premium for Group Coverage benefit if You are enrolled in Your Employer's group plan. For all other benefits, You must complete an enrollment application within 30 days of satisfying the eligibility requirement. You will also need to complete an enrollment form within 30 days before the beginning of each year to have benefits for the coming year.
Claims Pre-tax premium payments for group plan will be automatically deducted from payroll and paid to the insurance company on Your behalf. Beginning April 1, 2014, You will be given a Benny debit card to use for qualifying purchases through the healthcare reimbursement of the Flexible Spending Plan. Anytime You don't use Your Benny card, You will need to submit a claim to 3PAdministrators, the claims processor, by online submission, fax, email or mail. Your claim should include proper documentation that healthcare services were received by You or Your eligible dependent and that the charges were not reimbursed from another source. There are certain debit card purchases that may require additional substantiation after the point of sale. If that occurs, you will receive an email or letter explaining what You must provide to document the purchase. The information required when submitting a reimbursement request for dependent care services includes the name of the dependent for whom care was provided, the name and social security number or TIN of the day care provider, the dates of service and the amount.

For Answers to any Questions, Please Call:
3PADMINISTRATORS
608-779-3000 or 888-540-0094

DEFINITIONS

Actively at Work*:* Actively at Work means performing on a regular basis all customary occupational duties at the Employer's business establishment or another location of business when Your job requires travel. "Regular basis means being regularly scheduled to work at least 37 ½ hours per week. You will be deemed to be Actively-at-Work if You are absent from work due to a health factor. You will be considered Actively-at-Work if You are on a holiday or vacation that Your Employer has approved if You were Actively-at-Work on Your last regularly scheduled working day before such holiday or vacation. In no event will an Employee be considered Actively-at-Work if employment with Employer has been effectively terminated.

Administrative Services Manager: The Administrative Services Manager is 3PAdministrators who provides administrative services in connection with the operation of the Plan.

Change in Status: Change in Status will mean a significant life event that may allow a Participant to change their original election for participation in the Plan. These events are: marriage or divorce of the Participant; the adoption, birth or death of a child or other Dependent of the Participant; death of the Participant's Spouse; emancipation of a Dependent child of the Participant so that the Dependent is no longer eligible to participate; change in residence for the Participant; employment change for the Participant or the Participant's Spouse; or entitlement to Medicare or Medicaid. Employees may discontinue participation in the premium deduction if the Employee is regularly scheduled to work at least 30 hours per week and there is a status change that results in working less than 30 hours per week. This only applies if the Employee intends to enroll in other minimum essential coverage. An Employee who becomes eligible to enroll in Exchange coverage during an Exchange special or open enrollment period, may also discontinue the premium deduction if the Employee intends to enroll in the Exchange.

Child: Child means any of the following:

1. Your natural child under the age of 26 including any child for whom You are required to provide coverage under a Qualified Medical Child Support Order;
2. A child who, before reaching age 18, was either adopted by You or placed in Your home for adoption;
3. Your child of any age who because of a physical or mental disability is incapable of sustaining his or her own financial support or independent living, if the disability began before the child attained age 26 and while covered under this Plan. Coverage may continue for as long as the child remains disabled, unmarried and wholly dependent on You for financial support (consistent with the Internal Revenue Code). The Plan may require You at any time to submit a physician's statement certifying the child's physical or mental disability;
4. Your stepchild who is dependent on You for his/her principal support and maintenance and maintains residence with You; and
5. A foster child if he or she lives with You and who is dependent on You for his/her principal support and maintenance.

Code: Code refers to Internal Revenue Code of 1986, as amended.

Compensation: Compensation means all earned income, salary, wages and other earnings paid by Employer to a Participant, including amounts contributed by the Employer through a salary reduction agreement that cannot be included in gross income under Sections 125, 402(g)(3), 403(b) or 457(b) of the Code.

Dependent: Dependent means a Spouse or Child of a Participant.

Elect/Election/Elective Contribution: Election is the amount You request to be deducted from Your Compensation on a pre-tax basis.

Eligible Employee*:* Eligible Employee means an Employee eligible to participate in this Plan, as provided in the Eligibility and Entry Date section.

Employee: Employee means a person the Employer classifies as an Employee under W-2 provisions and has begun to perform the duties of his or her job. "Employee" does not include any of the following, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law Employee of the Employer: (a) any Employee who is not a full-time Employee, permanent part-time Employee under a collective bargaining agreement or Terms & Conditions of Employment or an elected official; (b) any leased Employee (including but not limited to those individuals defined as leased Employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary Employee, or casual Employee for the period during which such individual is so classified; (c) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency; (d) any Employee included within a unit of Employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under this Plan. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

Employer: Employer means The City of La Crosse.

Entry Date: Entry Date is the date You can join the Plan. The Entry Date is the first of the month following 60 days of qualifying employment, provided you have submitted a completed enrollment form to the Plan Administrator within 30 days of that date.

Grace Period: The Grace Period is the 2 ½ month period following the end of the Plan Year during which claims can be Incurred and reimbursed with funds from the previous Plan Year. The Grace Period ends on March 15th. Claims Incurred during the Grace Period may be submitted for reimbursement until the end of the Run-out Period which ends on March 31st.

Incurred: An expense is Incurred at the time the care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the care.

Plan: The Plan means the plan of flexible spending benefits established by the Employer and includes any amendments to the Plan.

Plan Administrator: Plan Administrator is the Employer, the sponsor of this Plan who is responsible for the day-to-day functions and engagement of the Plan. The Plan Administrator may employ other persons or firms to process claims and perform other Plan related services.

Plan Participant: A Plan Participant is an Eligible Employee who is a Participant in the Plan.

Plan Year: Plan Year will mean the 12 month period of January 1 through December 31.

Run-Out Period: The Run-Out Period is the time period following the end of the Plan Year during which claims Incurred during the Plan Year or Grace Period can still be reimbursed. The Run-Out Period is 3 months and ends on March 31st.

Salary Reduction: Salary Reduction is the amount specified by the Plan Participant that is reduced from Compensation pre-tax for purposes of contributing to the Plan.

Spouse: Spouse means an individual who is legally married to an Employee as determined under applicable state law (and who is treated as a spouse under the Code).

You and Your*:* You and Your refers to You as the Eligible Employee and Plan Participant.

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SECTION I

PRE-TAX PREMIUM

PRE-TAX PREMIUM PLAN

This pre-tax premium plan enables you to pay your share of premiums, if any, for group insurance sponsored by your Employer with pre-tax dollars. If You are responsible for any portion of premium under the Employer' sponsored plan(s), it will be deducted from your pay before income and social security taxes are withheld. This means you will not pay federal income tax, social security tax or Medicare tax on the amount of your premium payments. The amount you elect to pay under the pre-tax premium option may also be excluded from your income for state income tax purposes. The amount you elect to pay under this pre-tax premium option will not appear on your W-2 form as part of your income.

HOW THE PLAN WORKS

In order to participate in the pre-tax premium plan, you must be eligible to participate in your Employer's benefit plan(s) and must be enrolled in the plan(s) to qualify for the pre-tax premium plan. Participation in the pre-tax premium plan is automatic. Premium payments will be deducted pre-tax and paid directly to the insurance company, if you are responsible for paying any portion of the premium. You cannot change or discontinue participation during the year unless you experience a qualifying change. Premium elections will terminate at the time employment is terminated.

ELIGIBILITY AND PARTICIPATION

You are eligible to participate in the pre-tax premium plan if you meet the eligibility requirements of the group plan(s) and are enrolled for coverage.

CHANGES DURING THE YEAR

In general, your decision to participate in the pre-tax premium plan cannot be changed during the plan year, which is January 1 through December 31. This means that once you join, you can withdraw from the plan or change coverage only during the election period each December. Once a plan year begins, federal law allows you to make changes only under a limited number of circumstances.

One of the circumstances allowing a change is a change in family status. A change in family status includes events like marriage, divorce, death of a spouse or dependent, the birth or adoption of a child, a change in the employment status of a spouse, or a significant change in health coverage attributable to your spouse's employment. If any of these events occur, you will be allowed to stop or change your contributions in a manner consistent with your change in family status.

Federal law also allows you to make a change if your health insurance coverage significantly decreases or stops during the year, or if the cost for the coverage significantly increases during the year. If either event occurs, you may revoke your choice of group health coverage and replace it with similar coverage. Payroll deductions will be automatically adjusted with premium increases or decreases that occur during a plan year.

Certain Special Enrollment rights are also provided under the State Children's Health Insurance Program (SCHIP). If an Employee has declined enrollment in the Plan for him or herself or his or her Dependents because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the

government provided coverage. A request for enrollment must be made within 60 days after the government provided coverage ends.

Additionally, if an Employee has declined enrollment in the Plan for him or herself or his or her Dependents, and later becomes eligible for state assistance through a Medicaid or Children's Health Insurance Program that provides help with paying for Plan coverage, then there also may be a right to enroll for this Plan. The enrollment request must be made within 60 days after the determination of eligibility for state premium assistance.

An Employee who was expected to average at least 30 hours per week may drop group health plan coverage midyear if the Employee's status changes so that the Employee is expected to average less than 30 hours, even if the reduction of hours does not result in loss of eligibility for the Plan. The change must correspond to the Employee's intended enrollment in other minimum essential coverage. The new coverage must be effective no later than the first day of the second month following the month in which the group health coverage is dropped.

An Employee who is eligible to enroll in Exchange coverage during an Exchange special or open enrollment period, may drop group health plan coverage midyear if the change corresponds to the Employee's intended enrollment in Exchange coverage that is effective no later than the day after the last day of coverage in the group health plan.

If employment terminates during the year, you will continue to be covered for any period for which premiums have already been deducted from your pay. Under federal law, you, your spouse and your dependent child(ren) may also be eligible to continue your health insurance coverage at the group rate but only if you pay the full premium with after-tax dollars. You will receive information about continuation rights at the time you leave employment.

Your employer may change or terminate the plan at any time but is required to notify you of any changes that affect your benefits.

BENEFITS ARE PROVIDED UNDER THE INSURANCE PLAN

Benefits are provided under the insurance plan, not the pre-tax premium plan. The insurance plan states the types and amounts of benefits, the requirements for participating and other terms and conditions of participating in the medical insurance plan.

Your Employer may change or terminate the plan at any time but is required to notify you of any changes that affect your benefits.

CONTRIBUTIONS FOR COST OF COVERAGE

The annual contributions for premium payment benefits under the pre-tax premium plan is equal to the amount set by the Employer, which may or may not be the same amount charged by the insurance carrier.

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SECTION II

FLEXIBLE SPENDING

This Plan is intended to qualify as a "self-insured medical reimbursement plan" under Code § 105, and the healthcare expenses reimbursed under the Plan are intended to be eligible for exclusion from a Participant's gross income under Code § 105(b).

PARTICIPATION

Your participation in the flexible spending plan offers You reimbursement of healthcare expenses that are not covered by another plan through pre-tax payroll deductions, thereby also allowing You to save tax dollars.

All Eligible Employees who meet the eligibility requirements detailed in Eligibility and Entry Date section are able to participate. You must complete and submit Your enrollment form to the Plan Administrator within 30 days of meeting the eligibility requirement. Enrollment forms submitted more than 30 days after You meet the eligibility requirement will not be accepted and You will not be allowed to participate until the next Plan Year. A new enrollment form is required prior to the start of each Plan Year and must be submitted timely in order to participate. The enrollment form allows You to indicate the amount of pre-tax payroll deduction You request. Your signature on the form is also Your agreement with Your Employer that You wish to have Your Compensation reduced by the amount You Elect. That amount will not be subject to federal income taxation.

The laws governing flexible spending plans generally do not allow You to change Your Election during a Plan Year, but there are a few exceptions. If You experience one of the following life events that qualify as a Change in Status, You may change Your Election: marriage or divorce of the Participant; the adoption, birth or death of a Child or other Dependent of the Participant; death of the Participant's Spouse; emancipation of a Dependent Child of the Participant so that the Dependent is no longer eligible for coverage under the Plan; change in residence for the Participant; employment change for the Participant or the Participant's Spouse; or entitlement to Medicare or Medicaid. You must submit a Notice of a Change in Status to the Plan Administrator within 30 days of the change to allow a change of Election.

Certain Special Enrollment rights are also provided under the State Children's Health Insurance Program (SCHIP). If an Employee has declined enrollment in the Plan for him or herself or his or her Dependents because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government provided coverage. A request for enrollment must be made within 60 days after the government provided coverage ends.

Additionally, if an Employee has declined enrollment in the Plan for him or herself or his or her Dependents, and later becomes eligible for state assistance through a Medicaid or Children's Health Insurance Program that provides help with paying for Plan coverage, then there also may be a right to enroll for this Plan. The enrollment request must be made within 60 days after the determination of eligibility for state premium assistance.

Because contributions to the Plan are made through payroll deductions, participation ends when employment is terminated and Compensation from the Employer ceases, however COBRA continuation may apply in certain circumstances. If Your employment ends because of a COBRA qualifying event, You may elect COBRA and pay the required premium until the end of the current Plan Year. Other provisions may apply so it is recommended that You check with the Plan Administrator or the Administrative Services Manager. If You are rehired within 30 days of termination, You will be required to resume Your previous Election. If You are rehired more than 30 days after termination, You may resume Your previous Election or make a new Election.

You may also remain a Plan Participant during a period of leave under the Family Medical Leave Act (FMLA) if Your Employer is subject to this law. In general, employers with 50 or more employees must provide unpaid leave for eligible employees at the time of the birth or adoption of a child or at the time of a serious health condition affecting themselves or a family member. In order to continue participation during FMLA, You must make the premium payments by one of the following methods: pre-paying by submitting the amount that would be due during the leave; pay-as-You-go payments made on the same schedule as the payroll deductions; or You can choose the catch-up option and make the payments when You return from the FMLA leave.

You may elect to continue participation in the Plan if you are absent from employment with the Employer due to being in "uniformed service", as that term is defined by the Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"), The coverage period will extend for the lesser of 24 months or until You fail to apply for reinstatement or to return to employment with the Employer. You will be responsible for making the required Contributions for the period during which You are in "uniformed service". Such payments must be made in a manner similar to the alternatives described for the payment of contributions with respect to FMLA leave, as determined by the Employer, in its sole discretion.

If Your absence from employment with the Employer on account of being in "uniformed service" resulted in the termination of coverage under the group health insurance plan and/or the medical savings account portion (if any) of the Plan, You may reinstate such coverage without being subject to a new exclusion or waiting period requirement imposed by such group health plan and/or medical savings account, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the "uniformed service".

ELIGIBILITY AND ENTRY DATE

You are eligible for coverage under the Plan if You are an Eligible Employee who meets the eligibility requirements and are in one of the following classes: a full-time Employee, permanent part-time Employee covered under a collective bargaining agreement or Terms & Conditions of Employment; or an elected official. You must complete and submit an enrollment form to the Plan Administrator within 30 days of meeting the eligibility requirement. Your coverage begins on Your Entry Date which is the first of the month following 60 days.

If You fail to complete and submit Your Enrollment Form to the Plan Administrator within 30 days of meeting the eligibility requirement You are a late enrollee and will not be eligible to participate until the next Plan Year.

You must be actively at work on Your entry date. Coverage will be effective the day after You return to work for one full day if You are not actively at work on Your entry date.

You may submit claims for non-reimbursed medical expenses for Your Dependents.

Your participation in the Plan will end on the earliest of the following dates:

1. The date the Plan terminates; or
2. The date You cease to be an Eligible Employee for any reason; OR
3. The date You fail to pay required contributions while on an approved leave of absence.

You will have 90 days from the termination date to submit claims Incurred prior to the termination date.

A Plan Participant whose employment terminates may immediately rejoin the Plan with the same benefit Elections if the Participant is rehired within 30 days of termination and meets all other eligibility requirements. A terminated Participant who returns to work after more than 30 days separation of service will need to re-satisfy the eligibility requirements to re-enter the Plan. Any unused balances as of the date Your participation ends will be forfeited.

CONTRIBUTIONS AND REIMBURSEMENTS

Contributions to the Plan are made through pre-tax payroll deductions based on Your Election at enrollment and You cannot change Your election unless You experience a Change in Status. The full amount of Your annual contribution is available at any time during the Plan Year. You will have 3 months after the end of the Plan Year to submit claims Incurred during the Plan Year or the Grace Period. The Run-out Period ends on March 31st whether the claims were Incurred during the Plan Year or the Grace Period. Unused balances cannot be carried over to the subsequent Plan Year, except to the extent that the Grace Period applies, and cannot be cashed out or converted to other taxable or non-taxable benefits. Unused balances will be forfeited after the Run-out Period.

You have immediate access to Your flexible spending account by using the debit card that will be activated April 1, 2014. It is important to retain Your receipts when using the debit card. You may be required to provide additional substantiation of Your purchase by sending in copies of the receipts. For any other purchases, You must submit reimbursement requests to the Administrative Services Manager along with appropriate documentation that an expense was Incurred and not reimbursed by another source. For example, an explanation of benefits from Your health insurance plan showing a charge for services being applied to deductible would be sufficient certification.

If not using the debit card, You can request reimbursement in one of the following ways: online claim submission, mail, email or fax a completed claim form along with documentation. Claim forms can be obtained from Your Employer or by request from the Administrative Services Manager. Forms are also available on the Administrative Services Manager's website at www.3padmin.com.

Eligibility of claims and reimbursement will be in compliance with IRS Code.

EXCLUSIONS AND LIMITATIONS

The Plan will reimburse Participants only for expenses Incurred during the Plan Year or Grace Period by a Participant or his or her Spouse or Dependents for medical care as defined in Code § 213(d). A healthcare expense is Incurred at the time the care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the care.

The Plan will always exclude any expenses for which the Participant or other person incurring the expense is reimbursed through a group plan, other insurance or any other accident or health plan. If only a portion of a medical care expense has been reimbursed elsewhere (e.g., because the group health plan imposes co-payment or deductible limitations), then the Plan can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this section.

The amount available to You for reimbursement of healthcare expenses is the amount of Your Election, reduced by prior reimbursements for healthcare expenses Incurred during the Plan Year or Grace Period.

Eligible claims Incurred within the Plan Year or Grace Period may be reimbursed until the end of the Run-out Period on March 31st. Unused account balances will be forfeited after that time.

HOW TO SUBMIT A CLAIM

You can submit claims online through the Administrative Services Manager's website at www.3pa.com by choosing Member Log-in under the Employee tab and then clicking on Reimbursement Account Benefits. Log-in instructions will be provided after enrollment to allow access to the secure site. Any claims submitted online will require follow-up documentation that can be emailed, faxed or mailed using the contact information shown below. You can also submit reimbursement requests directly to the Administrative Services Manager either by mail, fax or email. Each request must include all information required by the reimbursement form, as well as appropriate documentation that the expense was Incurred and not reimbursed from any other source. Reimbursement forms are available from Your Employer or the Administrative Services Manager. You can also download reimbursement forms from the Administrative Services Manager's website, found in the Document Center under the Employee tab. Completed claim forms can be submitted to 3PAdministrators at:

3Padministrators
P.O. Box 247
2850 Midwest Drive, Suite 106
Onalaska, WI 54650

Or: Fax to 608-779-3009 or 877-540-0094

Or: Email to info@3pa.com

You may appeal an adverse determination on a claim by submitting a written request to the Plan Administrator. The request should include written comments and clear information detailing the basis of Your appeal. You also have the right to review documents pertinent to the administration of the Plan and the processing of Your claim. Your written appeal must be submitted within 180 days after receipt of the notice of adverse determination. After review, the Plan will respond to You in writing within 45 days from receiving Your appeal as to the Plan's decision. The response will include specific reasons for the decision and will refer to specific Plan provisions upon which the decision was based.

If the response to Your appeal upholds the initial determination, You have the right to a second appeal. This must also be submitted in writing within 180 days after receipt of the second notice of adverse determination and should include any additional information You may have acquired in relation to Your claim. The Plan may involve consultants and/or experts in reviewing the claim. The Plan's response to Your appeal will be provided in writing within 45 days.

Further review of the Plan's decision must be through binding arbitration, subject to the rules of the American Arbitration Association. This is the only recourse allowed for further review. The arbitrators will be bound by Wisconsin law and will not have any authority to award punitive or exemplary damages.

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SECTION III

DEPENDENT CARE ASSISTANCE

DEFINITIONS FOR THE PURPOSE OF THE DEPENDENT CARE ASSISTANCE PLAN

DCAP*:* Dependent Care Assistance Plan

Dependent*:* A Dependent is: (1) the employee's "qualifying Child" who has not yet attained age 13; or (2) a person who is physically or mentally incapable of self-care, who lives with an employee for more than half a year, and who is the employee's spouse, "qualifying Child" age 13 or older, or "qualifying relative." The terms "qualifying Child" and "qualifying relative" are defined in Code Section 152.

Dependent Care Expenses: Expenses Incurred by a Plan Participant for the care of a Qualifying Dependent necessary for You (and Your Spouse) to go to work or school, or for related household services which would be considered employment-related expenses under Section 21(b)(2) of the Code.

Qualifying Individual*:* Qualifying Individual means:

- a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1);
- a tax dependent of the Participant as defined in Code § 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
- a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

In the case of divorced or separated parents, however, a Qualifying Individual who is a child will, as provided in Code § 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)) and will not be treated as a Qualifying Individual with respect to the non-custodial parent.

PARTICIPATION

Your participation in this dependent care assistance plan (DCAP) offers You reimbursement with pre-tax dollars of dependent care expenses, such as daycare expenses, that are necessary for You (and Your Spouse) to work or go to school, thereby allowing You to save tax dollars.

If You first become eligible to participate in the Plan mid-year, You must submit Your completed Election form within 30 days of the date You satisfy the eligibility requirements to begin participation in the Plan on the date of qualifying employment. If You submit Your competed Election form more than 30 days after You satisfy the eligibility requirements, You will not be allowed to participate until the next Plan Year. You must submit a new Election form during the open Election period prior to the start of each Plan Year to participate for the next Plan Year. The Election form allows You to indicate the amount of pre-tax payroll deduction You request. Your signature on the form is also Your agreement with Your Employer that You wish to have Your Compensation reduced by the amount You Elect. That amount will not be subject to federal income taxation.

The laws governing dependent care assistance plans generally do not allow You to change Your Election during a Plan Year, but there are a few exceptions. If You experience one of the following life events that qualify as a Change in Status, You may change Your Election: marriage or divorce of the Participant; the adoption, birth or death of a Child or other Dependent of the Participant; death of the Participant's Spouse; emancipation of a Dependent Child of the Participant so that the Dependent is no longer eligible to participate; change in residence for the

Participant; employment change for the Participant or the Participant's Spouse; entitlement to Medicare or Medicaid or a change in cost or coverage. Notice of a Change in Status must be submitted to the Plan Administrator within 30 days of the date the Change of Status event occurs to allow a change of Election.

You may remain a Plan Participant during a period of leave under the Family Medical Leave Act (FMLA) if Your Employer is subject to this law. In general, employers with 50 or more employees must provide unpaid leave for eligible employees at the time of the birth or adoption of a child or at the time of a serious health condition affecting himself or herself or a family member. In order to continue participation during FMLA, You must make the contribution payments by one of the following methods: pre-paying by submitting the amount that would be due during the leave; pay-as-You-go payments made on the same schedule as the payroll deductions; or You can choose the catch-up option and make the payments when You return from the FMLA leave.

ELIGIBILITY AND ENTRY DATE

You are eligible for coverage under the Plan if You are an Eligible Employee who meets the eligibility requirements and are in one of the following classes: a full-time Employee, permanent part-time Employee covered under a collective bargaining agreement or Terms & Conditions of Employment; or an elected official. You must complete and submit an enrollment form to the Plan Administrator within 30 days of meeting the eligibility requirement. Your coverage begins on Your Entry Date which is the first of the month following 60 days.

You elect coverage under this Plan by submitting Your completed enrollment form to the Employer within 30 days of the date You satisfy the eligibility requirements. If the Employer receives Your Election form more than 30 days after Your Entry Date, You are a late enrollee and will not be eligible to participate until the next Plan Year.

You must be actively at work on Your entry date. Coverage will be effective the day after You return to work for one full day if You are not actively at work on Your entry date.

Your participation in the Plan will terminate on the earliest of the following:

1. The date the Plan terminates; or
2. The date You cease to be an Eligible Employee due to retirement, termination of employment, reduction in hours, layoff, or any other reason; or
3. The date You fail to pay required contributions while on an approved leave of absence.

You will have 90 days from the termination date to submit claims Incurred prior to the termination date.

A Plan Participant whose employment terminates may immediately rejoin the Plan with the same benefit Elections if the Participant is rehired within 30 days of termination and meets all other eligibility requirements. If a terminated Participant returns to work after more than 30 days separation of service, they will need to re-satisfy the eligibility requirements to re-enter the Plan. Any unused balances prior to termination will be forfeited.

CONTRIBUTIONS AND REIMBURSEMENTS

Contributions to the Plan are made through pre-tax payroll deductions based on Your Election and that Election cannot be changed unless You experience a Change in Status.

The maximum annual benefit amount that You may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses Incurred in any Plan Year will be $5,000 or, if lower, the maximum amount that You have reason to believe will be excludable from Your

income at the time the Election is made as a result of the applicable statutory limit for You. The applicable statutory limit for You is the smallest of the following amounts:

- the Participant's earned income for the calendar year;
- the Earned Income of the Participant's Spouse for the calendar year (note: a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense; and (2) is either physically or mentally incapable of self-care or is a student will be deemed to have earned income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or
- either $5,000 or $2,500 for the calendar year, as applicable:
  (1) $5,000 for the calendar year if one of the following applies:
  - the Participant is married and files a joint federal income tax return;
  - the Participant is married, files a separate federal income tax return, and meets the following conditions: (a) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (b) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (c) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or - the Participant is single or is the head of the household for federal income tax purposes; or
  (2) $2,500 for the calendar year if the Participant is married and resides with the Spouse but files a separate federal income tax return.

You will have 3 months after the end of the Plan Year to submit claims Incurred during the Plan Year or the Grace Period. The Run-out Period ends on March 31st whether the claims were Incurred during the Plan Year or the Grace Period. Unused balances cannot be carried over to the subsequent Plan Year, except to the extent that the Grace Period applies, and cannot be cashed out or converted to other taxable or non-taxable benefits. Unused balances will be forfeited after the Run-out Period.

The Plan will reimburse claims for Dependent Care Expenses Incurred for the care of any Qualifying Individual consistent with IRS Code and corresponding regulations. For divorced parents, a child will be considered the Dependent of the custodial parent even when the custodial parent does not claim the Child on his/her income tax return. Dependent Care Expenses must be for the care of Qualifying Individual and necessary to enable the Participant or the Participant's Spouse to work or look for employment. Dependent Care Expenses also qualify if the Participant's Spouse is a full-time student or physically or mentally incapable of self-care.

You must submit Dependent Care Expense reimbursement requests to the Administrative Services Manager on the form designated by the Plan Administrator. Each request for reimbursement must include the following documented information:

- name of the person(s) for whom the expenses were Incurred;
- the name of the person, organization or entity to whom the Expense was or is to be paid,
- and taxpayer identification number (Social Security number, if the recipient is a person);
- the nature of the expenses;
- the date the expenses were Incurred;
- the amount of expenses that have not been reimbursed by any other source and a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses Incurred during the same calendar year, will exceed the applicable statutory limit for the Participant; and

- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The request for reimbursement must be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been Incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request.

An annual report will be supplied to all Participants on or before January 31, showing the total Dependent Care Expenses reimbursed in the previous Calendar Year.

EXCLUSIONS AND LIMITATIONS

The Plan will only reimburse those services and charges that are eligible under the IRS Code and corresponding regulations.

The amount available to You for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to Your DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Consequently, Your DCAP Account may not have a negative balance during a Plan Year.

Eligible claims Incurred within the Plan Year or Grace Period may be reimbursed up through the end of the Run-out Period which ends on March 31st. Unused account balances will be forfeited after that time.

HOW TO SUBMIT A CLAIM

You submit reimbursement requests directly to the Administrative Services Manager by mail, fax or email. Each request must include all information required by the reimbursement form, as well as appropriate documentation that the expense was Incurred. Reimbursement forms are available from Your Employer, the Administrative Services Manager or online www.3pa.com by clicking on the Document Center under the Employee tab. Completed claim forms can be submitted to 3PAdministrators at:

3PAdministrators
P.O. Box 247
2850 Midwest Drive, Suite 106
Onalaska, WI 54650

Or: Fax to 608-779-3009 or 877-540-0094

Or: Email to info@3pa.com

You may appeal an adverse determination on a claim by submitting a written request to the Plan Administrator. The request should include written comments and clear information detailing the basis of Your appeal. You also have the right to review documents pertinent to the administration of the Plan and the processing of Your claim. Your written appeal must be submitted within 180 days after receipt of the notice of adverse determination. After review, the Plan will respond to You in writing within 45 days from receiving Your appeal as to the Plan's decision. The response will include specific reasons for the decision and will refer to specific Plan provisions upon which the decision was based.

If the response to Your appeal upholds the initial determination, You have the right to a second appeal. This must also be submitted in writing within 180 days after receipt of the second notice of adverse determination and should include any additional information You may have acquired in relation to Your claim. The Plan may involve consultants and/or experts in reviewing the claim. The Plan's response to Your appeal will be provided in writing within 45 days.

Further review of the Plan's decision must be through binding arbitration, subject to the rules of the American Arbitration Association. This is the only recourse allowed for further review. The arbitrators will be bound by Wisconsin law and will not have any authority to award punitive or exemplary damages.

SECTION IV

GENERAL INFORMATION

GENERAL PLAN INFORMATION

PLAN NAME: The City of La Crosse Section 125 Cafeteria Plan

EMPLOYER: The City of La Crosse

EMPLOYER ID: 39-6005490

PLAN YEAR: January 1 through December 31

PLAN NUMBER: 501

PLAN SPONSOR: The City of La Crosse
400 La Crosse Street
La Crosse, WI 54601

AGENT FOR SERVICE OF LEGAL PROCESS: The City of La Crosse
400 La Crosse Street
La Crosse, WI 54601
Phone: 608-789-7595

ADMINISTRATIVE SERVICES MANAGER: 3PAdministrators
2850 Midwest Drive, Suite 106
P.O. Box 247
Onalaska, WI 54650
Phone: 608-779-3000
Fax: 608-779-3009

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act is a federal law that applies to Employers with 50 or more Employees, and provides that an Employee may elect to continue coverage under this Plan during a period of approved FMLA leave at the same cost to the Employee as it would have been had the FMLA leave not been taken.

If this Plan is established while You are on FMLA leave, Your coverage will be effective on the same date as it would have been had You not taken leave. If provisions under the Plan change while You are on FMLA leave, the changes will be effective for You on the same date as they would have been had You not taken leave.

EMPLOYEE ELIGIBILITY

You are an Eligible Employee under the Act if all of the following conditions are met:

- You are an Employee who has been employed with the Employer for a total of at least 12 months;
- You have worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and
- You are employed at a worksite that employs at least 50 Employees within a 75-mile radius.

FAMILY AND MEDICAL LEAVES

Coverage under this Plan can be continued during a period of FMLA leave. Coverage under FMLA leave is limited to a total of 12 weeks during any 12-month period that follows:

- The birth of Your child;
- The placement of a child with You for adoption or foster care;
- You take leave to care for a Spouse, Son, Daughter or Parent who has a Serious Health Condition; or
- You take leave due to a Serious Health Condition that makes You unable to perform the functions of Your position.
- A qualifying exigency arising out of the fact that the Spouse, son daughter or parent of the Employee is on active military duty, or has been notified of an impending call to active duty status in support of a contingency operation.

Coverage under this Plan can be continued up to 26 weeks in a single 12 month period for an Employee who is the Spouse, son daughter, parent or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty.

Your leave may be paid (accrued vacation time, personal leave or sick leave) or unpaid. The Employer has the right to require that all paid leave, including earned vacation time and/or sick time, be used prior to providing any unpaid leave.

The Employee must continue to pay the Employee portion of the Plan contribution during the FMLA leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

NOTICE OF LEAVE

You must notify the Employer at least 30 days prior to beginning any leave under the FMLA. If Your leave was not foreseeable, You must notify the Plan Administrator of Your FMLA leave as soon as possible. The Plan Administrator has the right to require medical certification to support Your request for leave due to Your or Your family member's Serious Health Condition.

MAXIMUM LEAVE PERIOD

The maximum FMLA leave You may take during any 12-month period is 12 weeks. If You and Your Spouse are both employed by the Employer, FMLA leave may be limited to a combined period of 12 weeks, for both spouses, when FMLA leave is due to:

- The birth or placement for adoption of a child; or
- The need to care for a Parent.

The maximum FMLA leave You may take can be extended to 26 weeks in a single 12 month period if You are the spouse, son, daughter, parent or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty. Military caregiver leave is available during a single 12 month period and the maximum 26 weeks is a combined total of all types of FMLA leave.

TERMINATION BEFORE THE MAXIMUM LEAVE PERIOD

Your coverage under this Plan will continue until Your FMLA leave ends, up to a maximum of 12 weeks from the date Your FMLA leave began. Coverage may end prior to this under the following circumstances:

- Your coverage under this Plan will end if You decide not to return to work; or
- if You do not pay Your portion of the cost for coverage within 30 days of its due date.

Notice of termination must be provided at least 15 days prior to the termination. If You do not return to work when coverage under the Act ends, You will be eligible for COBRA Continuation of Coverage at that time, if applicable.

RECOVERY OF PLAN CONTRIBUTIONS

The Plan Administrator has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA leave if the Employee does not return to work at the end of the leave. This right will not apply if failure to return is due to circumstances beyond the Employee's control.

REINSTATEMENT OF COVERAGE UPON RETURN TO WORK

The law requires that coverage be reinstated upon the Employee's return to work. On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA leave had not been taken. The Waiting Period and the Pre-Existing Condition limitation will be credited as if You had been continually covered under the Plan.

DEFINITIONS FOR PURPOSES OF THE FAMILY MEDICAL LEAVE ACT

For this section only, the following terms are defined as stated.

1. **Serious Health Condition** is a sickness, injury, impairment or physical or mental condition that involves:

   - Inpatient care in a Hospital, Hospice or Qualified Treatment Facility, including any period of incapacity due to a serious health condition, or treatment of or recovery from a serious health condition;
   - Continuing treatment by a Qualified Practitioner, including any period of incapacity: For more than three consecutive calendar days, if a Qualified Practitioner is consulted two or more times during the period or if a Qualified Practitioner is consulted once and a continuing treatment program is provided;
   - Due to pregnancy or prenatal treatment, even if treatment is not provided or it does not last for more than three days;
   - Due to a chronic condition (i.e. a condition which required periodic treatments by a Qualified Practitioner and continues over an extended period of time,

whether incapacity is continuous or periodic), even if treatment is not provided or it does not last for more than three days;

- Which is permanent or long term due to a condition which requires the supervision of a Qualified Practitioner, but for which treatment is ineffective; or
- To receive multiple treatments from a Qualified Practitioner for restorative surgery due to an Accident or Sickness or for a condition that would likely result in a period of incapacity of more than three days without such treatment.

2. **Spouse** is Your lawful husband or wife.

3. **Son or Daughter** is Your natural blood-related child, adopted child, stepchild, foster child, a child placed in Your legal custody or a child for whom You are acting as the parent in place of the child's natural blood related parent. The child must be:

- Under the age of 18; or
- Over the age of 18, but incapable of self-care due to a mental or physical disability

4. **Parent** is Your natural blood related parent or someone who has acted as Your parent in place of Your natural blood related parent.

NOTE: For complete information regarding Your rights under the Family and Medical Leave Act, contact The Plan Administrator.

HIPAA PROVISIONS

PROVISION OF PROTECTED HEALTH INFORMATION TO EMPLOYER

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Section 125 Cafeteria Plan. When this health information is provided from the Plan to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected Health Information includes information of persons living or deceased. The Employer will have access to PHI from the Cafeteria Plan only as permitted under this Article or as otherwise required or permitted by HIPAA.

PERMITTED DISCLOSURE OF ENROLLMENT/DISENROLLMENT INFORMATION

The Section 125 Cafeteria Plan may disclose to the Employer information on whether the individual is participating in the Plan.

PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Cafeteria Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan. "Summary Health Information" means information: (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic

information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

PERMITTED AND REQUIRED USES AND DISCLOSURE OF PHI FOR PLAN ADMINISTRATION PURPOSES

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification, the Cafeteria Plan may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Cafeteria Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. In no event will the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

CONDITIONS OF DISCLOSURE FOR PLAN ADMINISTRATION PURPOSES

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Cafeteria Plan, the Employer will:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Cafeteria Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

The Employer also agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Cafeteria Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA any security incident of which it becomes aware.

ADEQUATE SEPARATION BETWEEN PLAN AND EMPLOYER

The Employer will allow the persons designated in its Adoption Agreement access to PHI in addition to payroll staff performing Cafeteria Plan functions; the Plan Administrator; and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Plan (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons will have access to PHI. These specified employees (or classes of employees) will only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee will be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's procedures. The Employer will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

CERTIFICATION OF PLAN SPONSOR

The Plan will disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure in this section.

GENERAL PROVISIONS

NAMED FIDUCIARY

The Employer is the named fiduciary but will not incur any liability for any acts or for failure to act except for willful misconduct by the Employer or willful breach of the Plan provisions.

AUTHORITY OF THE PLAN ADMINISTRATOR

The Plan is administered by the Plan Administrator. The Employer may appoint an individual or entity to be the Plan Administrator. The Employer may appoint a new Plan Administrator or the Employer will serve as the Plan Administrator if the Plan Administrator resigns, is unable to perform, is dissolved, or is removed from the position.

The Plan Administrator will administer this Plan consistent with its terms and establish its policies, interpretations, practices, and procedures. The Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise pertaining to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, will receive the maximum deference provided by law and will be final and binding on all parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Plan Participant is entitled to them.

The duties of the Plan Administrator include the following:

- To administer the Plan consistent with its terms;
- To determine all questions of eligibility, status and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes that may arise relative to a Plan Participant's rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

- To keep and maintain the Plan documents and all other records pertaining to the Plan;
- To appoint and supervise an Administrative Service Manager to pay claims;
- To delegate to any person or entity such powers, duties and responsibilities it deems appropriate; and
- To perform each and every function necessary for or related to the administration of the Plan.

RIGHT OF THE EMPLOYER TO AMEND OR TERMINATE THE PLAN

The Employer expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Employer, through its governing body, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any).

Any such amendment, suspension or termination will be enacted, if the Employer is a corporation, by resolution of the Employer's directors and officers, which will be acted upon as provided in the Employer's Articles of Incorporation or Bylaws, as applicable, and consistent with applicable federal and state law. If the Employer is a different type of entity, then such amendment, suspension or termination will be taken and enacted consistent with applicable federal and state law and any applicable governing documents. In the event that the Employer is a sole proprietorship, then such action will be taken by the sole proprietor, in his own discretion. The Employer will notify Plan Participants of any amendment to or termination of the Plan.

If the Plan is terminated, the rights of the Plan Participants are limited to eligible claims Incurred before termination. All amendments to this Plan will become effective as of a date established by the Employer.

Plan assets will be allocated and disposed of for the exclusive benefit of Plan Participants, except that any taxes and administration expenses may be paid from the Plan's assets.

FUNDING THIS PLAN

All of the amounts payable under this Plan will be paid from the general assets of the Employer. Nothing in this Plan 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 will 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. Although the Employer has responsibility for the payment of benefits out of its general assets, it may hire an unrelated third-party paying agent to make benefit payments on its behalf. The maximum contribution that a Participant may elect as Employer and Participant contributions is the total of the maximums stated in the Plan or Election Form/Salary Reduction Agreement or as may be determined by the Employer.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Plan Participant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Plan Participant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Plan Participant must complete a form that can be obtained from the Plan Administrator or the Administrative Service Manager. In the event a Plan Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Plan Participant, unless the Plan Participant directs the Plan Administrator, in writing, to the contrary.

NO GUARANTEE OF TAX CONSEQUENCES

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It will be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

CLERICAL ERROR/DELAY

Clerical errors made on the records of the Plan and delays in making entries on such records will not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage will be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Plan Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

CONFORMITY WITH APPLICABLE LAWS

This Plan will be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

FAILURE TO ENFORCE PLAN PROVISIONS

The Plan's failure to enforce any provision of the Plan will not affect the right, thereafter, to enforce such provision nor affect the right to enforce any other provision of the Plan.

FREE CHOICE PROVIDER

Any Plan Participant may select any provider of service for care, treatment, services or supplies he wishes. This Plan does not dictate the choice of provider nor will it interfere in the provider/patient relationship or the course of treatment.

HEADINGS

The headings used in this Plan Document are used for convenience of reference only. Plan Participants are advised not to rely on any provision because of the heading.

LIMITATION ON ACTIONS

Any action with respect to a fiduciary's breach of any responsibility, duty or obligation under this Plan must be brought within one year after the act or omission is alleged to have occurred. "How to Submit a Claim" in Sections II and III is the exclusive procedure for making a claim for benefits under this Plan.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan will be deemed to have been waived, and there will be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

NOT A CONTRACT

This Plan Document and Summary Plan Description, as well as any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document will not constitute a contract of any type between the Plan Administrator and any person. Nothing in this Plan Document and Summary Plan Description gives any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

PRONOUNS

All personal pronouns used in the Plan will include either gender unless the context clearly indicates otherwise.

PROTECTION AGAINST CREDITORS

Benefit payments under the Plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish these will not be recognized. The Plan Administrator may, at its sole discretion, terminate Your interest in the benefits payable under this Plan, in which event the Plan will then apply the amount of the payment to the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the Plan Participant. Such payment will fully discharge the Plan's liability to the extent of the payment.

RIGHT OF RECOVERY PROVISION

Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Plan Participant on whose behalf the payment was made.

A Plan Participant, Provider, another benefit plan, insurer, or any other person or entity who receives a payment for expenses exceeding the amount of benefits available under the terms of the Plan or on whose behalf such payment to the Plan was made, will return the amount of such erroneous payment to the Employer within 30 days of discovery or demand. The Plan Administrator will have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator will have the sole discretion to choose who will repay the Employer for an erroneous payment and such payment will be reimbursed in lump sum or deducted from future claims presented for processing.

Any payments made on claims for reimbursement not in accordance with the above provisions will be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan will be entitled to recover its litigation cost and actual attorney's fees Incurred.

RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Plan Participant for benefits from this Plan. In so acting, the Plan Administrator will be free from any liability that may arise with regard to such action. Any Plan Participant claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision.

WRITTEN NOTICE

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan will be interpreted to conform to the minimum requirements of such law.

GOVERNING LAW

This Plan will be construed, administered, and enforced according to the internal laws of the State of Wisconsin, to the extent not superseded by the Code or any other federal law.

MEDICAL INSURANCE PLAN 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.