THE LINCOLN ELECTRIC COMPANY

FLEXIBLE SPENDING ACCOUNT BENEFIT PLAN
and
SUMMARY PLAN DESCRIPTION

This document, together with any applicable program documents, constitute the written plan document required by ERISA Section 402 and the Summary Plan Description required by ERISA Section 102.

The Lincoln Electric Company ("Employer") established The Lincoln Electric Welfare Benefit Plan, effective January 1, for the exclusive benefit of Eligible Employees and their eligible family members. The term "Employer" includes any successor, and for eligibility purposes the affiliates of the Employer that the Plan Administrator has designated for participation in the Plan.

This document serves as both the plan document and summary plan description for the Flexible Spending Account Plan ("Plan"). The Plan provides certain health and welfare benefits through component benefit programs.

Each of the benefit programs ("Programs") is described in a separate written plan document, insurance certificate or contract, benefit summary, or other governing document. The Program documents together with this document constitute the written plan and summary plan description. This document sets forth the terms of the Plan and addresses certain information that may not be included in the Program documents and is not intended to give you any substantive right to benefits not already provided by the Programs.

If the terms of this document are inconsistent with the terms of the written Program documents, then the terms of the Program documents will control, unless otherwise required by applicable law. You should read the Program documents and this document together carefully to understand your benefits. Contact the Program provider or the Plan Administrator if you wish to receive a copy of the Program documents.

PART II – PLAN INFORMATION

Plan Name:	The Lincoln Electric Welfare Benefit Plan
Plan Number:	502
Employer's Tax Identification Number:	34-0359955
Plan Type:	Welfare benefit plan providing (check all that apply): Health Flexible Spending Account, non-HSA compatible ☒ Grace period, with an end-date of March 15th following the plan-year end date for calendar year plans, or as follows for non-calendar year plans or a shorter grace period: _____ ☐ Carryover (Enter amount, $0 to $550): _____ ☐ No grace period or carryover provision applies Health Flexible Spending Account, HSA compatible (limited to dental, vision, preventive care, or post-deductible expenses) ☒ Grace period, with an end-date of March 15th following the plan-year end date for calendar year plans, or as follows for non-calendar year plans or a shorter grace period: _____ _____ ☐ Carryover (Enter amount, $0 to $550): _____ ☐ No grace period or carryover provision applies **Benefits not subject to ERISA** **Dependent care assistance** ☒ fDependent Care Flexible Spending Account ☒ Grace period, with an end-date of March 15th following the plan-year end date for calendar year plans, or as follows (e.g., for non-calendar year plans or a shorter period): _____ ☐ No grace period provision applies
Plan Year:	January 1 to December 31
Plan Sponsor:	The Lincoln Electric Company 22801 St. Clair Ave. Cleveland OH 44117
Plan Administrator and Named Fiduciary:	The Employer will be the Plan Administrator and Named Fiduciary for the ERISA Benefits of the Plan: The Lincoln Electric Company 22801 St. Clair Ave. Cleveland OH 44117 216-481-8100
Claims Fiduciaries:	Unless otherwise specified in each Program document, the insurance company or other entity providing each Program is the named fiduciary for, and has the authority to decide, claims for benefits and appeals under its respective Program.
Service of Legal Process:	☒ Plan Administrator ☐ Other: .
Eligibility:	Coverage begins (check one): ☐ Date of hire ☐ First day of the month following date of hire ☒ First day of the month following 30 days of employment ☐ First day of the month following 60 days from date of hire ☐ As specified in the Program Participation Table (Appendix B)

PART III – for the Health FSA ELIGIBILITY AND PARTICIPATION

Eligibility and Participation

An "Eligible Employee" with respect to the Plan is any Employee who is eligible to participate in and receive benefits under one or more of the Programs in accordance with the terms and conditions of the applicable Program. An owner or self-employed individual may constitute an "Employee" under the Plan in accordance with policies established by the Employer. To determine whether you or your family members are eligible to participate in a Program, please review the applicable Program document.

Need for Enrollment: Time Limits

Some of the Plan's Programs may be provided automatically to Eligible Employees, while other Programs require completion of annual elections or applications for enrollment. Certain Programs allow Eligible Employees to pay for their share of the cost of coverage on a pre-tax basis. The details of these administrative requirements are described in the Program documents.

For Programs that require enrollment, newly Eligible Employees must generally enroll within certain time periods after being hired or first becoming eligible, as described in the Program documents. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before the start of each Plan Year, unless circumstances give rise to special enrollment rights described below, or unless other enrollment opportunities are available for a particular Program.

Special Enrollment Rights

In certain circumstances enrollment in Programs that are group health plans (for example, heath flexible spending account Program) may be available at times outside the regular open enrollment period (this is referred to as "special enrollment"). The applicable Program documents should explain any special enrollment rights.

When Participation Begins and Ends

Your coverage under the Plan will begin once you have enrolled in any Program. For information about when coverage for a particular Program begins, please review the applicable Program document.

Coverage under a particular Program stops according to the terms and conditions reflected in the Program documents. Termination of coverage under a particular Program does not necessarily mean your coverage under the Plan in general terminates. You should consult the applicable Program documents for specific information.

In general, your coverage under this Plan terminates on the last day of the month in which you terminate employment with the Employer. Coverage under the Plan may also terminate if you fail to pay your share of premiums, if your hours drop below the required eligibility threshold, if you submit false claims, if the Plan terminates and for certain other reasons described in the Program documents. Coverage for your family members under the Plan stops when your coverage stops, if you fail to provide proof of continued eligibility as may be required by the Plan Administrator, and for other reasons specified in the Program documents (for example, divorce, dissolution of domestic partnership, or a dependent's attaining age limit).

Continuation Coverage Under COBRA and USERRA

There are several types of continuation coverage that may apply to particular Programs. For more information, see the Program documents.

If coverage under a group health plan (for example heath flexible spending account Program) for you or your eligible family member(s) ceases because of certain "qualifying events" specified in the Consolidation Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you and your eligible family member(s) may have the right to purchase continuation coverage for a temporary period of time.

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

PART IV – SUMMARY OF PLAN BENEFITS for the Health FSA

Available Benefits and Contributions

The Plan provides you and your eligible family members with benefits under the Programs. A summary of each Program provided under the Plan is set forth in the Program documents. The Programs under the Plan may change from time to time, and not all benefits may be offered to all participants in this Plan.

Funding Medium and Type of Plan Administration

Benefits under the Plan are self-funded by the Employer. The Employer is responsible for paying claims with respect to the self-funded Programs and claims are paid solely from the Employer's general assets. See the Program documents for information about how other benefits are funded.

The cost of the benefits provided through the Plan will be funded by contributions made by the Employee, which may be pre-tax salary reduction contributions. The Employer will determine and periodically communicate your share of the cost of the benefits provided through each Program, and it may change that determination at any time.

The Employer will make its contributions in an amount that (in the Employer's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by Employee contributions. With respect to benefits that are self-funded, the Employer will pay benefits from Employee contributions and the Employer's general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

Circumstances That May Affect Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates, including upon termination of the Plan. Benefits under a particular Program will cease for an Employee or an Employee's family member when the individual ceases to be eligible for the particular Program.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. Consult the Program documents for additional information.

The Plan has the right to recover overpaid benefits and to seek subrogation or reimbursement in certain circumstances and with respect to certain Programs. The applicable Program documents provide additional information about the termination, denial, or loss of benefits, and about the Plan's recovery, subrogation, and reimbursement rights.

Administrative Requirements and Time Frames

As described in the Program documents, there may be other reasons that a claim for benefits is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. Please consult the applicable Program documents.

Rebates, Refunds, and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract or third party administrator arrangement shall be allocated consistent with applicable fiduciary obligations under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

PART V –PLAN ADMINISTRATION for the Health FSA

Plan Administrator

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities.

To the fullest extent permitted by law, the Plan Administrator, and any other fiduciary with respect to the Plan, shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of the Plan (including the Programs), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (including the Programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion.

The Plan Administrator may delegate its responsibilities for deciding claims for benefits under the Programs to certain insurance companies and third party administrators who serve as the named fiduciaries (or "Claims Fiduciaries") for their respective Programs. Claims Fiduciaries are responsible for (a) determining eligibility for and the amount of any benefit payable under their Program(s); and (b) prescribing claims procedures to be followed and the claims forms to be used pursuant to their Program(s). Claims Fiduciaries have the discretionary authority to interpret the Plan and Program documents in order to make benefit determinations under their Program(s).

Plan Amendment and Termination

The Employer, as plan sponsor, has the right to amend or terminate the Plan or any Program, in whole or in part, at any time with or without retroactive effect, to the extent permitted by law. The Plan may be amended or terminated by a written instrument duly adopted by the Employer or any of its authorized delegates. If the Employer terminates a Program, plan assets will be allocated and distributed in accordance with the terms of the Program document or as otherwise permitted by law.

From time to time the Plan Administrator shall update and revise Appendix A and any Program and insurance company or third party administrator listed on Appendix A. Any such update or revision of Appendix A or any Program or insurance company or third party administrator listed on Appendix A shall be considered a duly authorized amendment of this Plan.

Your Questions

If you have any general questions regarding whether you are eligible to enroll in or change your elections under the Plan or a particular Program offered through the Plan, please contact the Plan Administrator or its designee for enrollment support.

If you have any question regarding benefits, coverage, or the amount of any benefit payable under the Programs in which you are enrolled, please contact the appropriate insurance company or third party administrator for the applicable Program.

PART VI –CLAIMS AND APPEALS PROCEDURES for the Health FSA

Claims and Appeals Process

To obtain benefits under a Program, you must follow the claims procedures under the applicable insurance contract or Program document. Your claim will be decided in accordance with the claims procedure incorporated in the applicable Program document, as required by ERISA (if ERISA applies) or other applicable law. The Plan Administrator, insurer, or third party administrator (as applicable) has the right to obtain independent medical advice and to require such other information as it deems necessary in order to decide a claim.

If your claim for benefits is denied in whole or in part, you may file an appeal as described in the applicable Program document for a review of the denied claim. Your appeal will be decided in accordance with the reasonable appeals procedure incorporated in the applicable Program document, as required by ERISA (if ERISA applies) or other applicable law. If the Program is subject to provisions of ERISA requiring external review, procedures to that effect will be available.

Claims Deadline

Unless specifically provided otherwise under the terms of an applicable Program document or pursuant to applicable law, a claim for benefits under this Plan (including the Programs) must be made within one (1) year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Eligible Employee or covered family member to make sure this requirement is met.

Limitations Period for Filing Suit

Unless specifically provided otherwise under the terms of an applicable Program document or pursuant to applicable law, a suit for benefits under this Plan must be brought within one (1) year after the date of a final decision on the claim in accordance with the applicable claims procedures.

Exhaustion of Administrative Remedies

In general, you must appeal a denied claim for benefits in order to preserve your right to sue for those benefits. If you do not appeal on time, then you may lose your right to file suit in a state or federal court.

PART VII – GENERAL INFORMATION for the Health FSA

Furnishing of Information

Eligible Employees shall provide to the Plan Administrator, insurance companies, and third party administrators information, documentation, and evidence, as may be requested by the Plan Administrator or applicable insurance company or third party administrator for the purpose of administration of the Plan or to verify eligibility for or entitlement to benefits under the Plan.

Anti-alienation

Your benefits and rights under this Plan (including the right to request documents or bring a lawsuit under ERISA) cannot be transferred or assigned to any other person or entity. Nothing in this Plan (including the Programs) shall be construed to make the Plan or Employer liable to any third party to whom an Eligible Employee or covered family member may be liable for medical care, treatment, or services, and direct payments to a provider will not constitute a waiver of the anti-assignment provisions under the Plan.

No Contract of Employment or Vested Rights

The Plan, including the Programs, shall not be construed as constituting, a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time, and no Employee or other participant shall have any vested rights to benefits provided under the Plan or under any Program.

Your ERISA Rights

Note that this Statement of ERISA Rights applies only to Programs that are governed by ERISA. Non-ERISA plans are not subject to this Statement.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series), if any, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report (when such report is required).

- Under certain circumstances, continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Program documents on the rules governing your COBRA continuation coverage rights.

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to

appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator's decision (or lack thereof) concerning the qualified status of a medical child support order, then you may file suit in federal court.

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

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A

The intention of the Employer is that, wherever appropriate, portions of the Plan shall qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the Benefits which an Employee elects to receive under such portions of the Plan be includable or excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

APPENDIX B

PROGRAM PARTICIPATION TABLE

Plan Type	Who is eligible?	When may coverage begin?
Health Flexible Spending Account, non-HSA compatible	**Employees working 30 or more hours per week**	First day of the month following 30 days of employment
Health Flexible Spending Account, HSA compatible (limited to dental and vision)	**Employees working 30 or more hours per week**	First day of the month following 30 daysof employment
Dependent Care Flexible Spending Account	**Employees working 30 or more hours per week**	First day of the month following 30 days of employment

APPENDIX C

QUESTIONS AND ANSWERS

Your Employer is pleased to sponsor this employee benefit program for you and your fellow Employees. The following questions and answers represent a summary of the Health Care and Dependent Care Spending Accounts program. This document should not be construed as tax, medical, or legal advice; please consult your advisor regarding your personal situation. Whenever the word "we" is used in this document, it refers to the Employer.

What is a Spending Account?

A Spending Account allows you to set aside part of your wages on a pre-tax basis (before income and employment taxes are calculated). The Health Care Account covers eligible Health Care Expenses. The Dependent Care Account covers eligible Dependent Care Expenses.

How does a Spending Account work?

You enroll for a certain amount for each type of account and then the Employer funds your account with deductions from your paycheck throughout the Plan Year. These deductions are taken before taxes are applied to your earnings. (This is how you save.) For the Health Care Account, your election amount is available to pay benefits beginning on the first day of coverage. For the Dependent Care Account, your account is funded by your payroll deductions as they are taken.

You can use your account to pay for any eligible expenses you incur during your Coverage Period. Your account balance will be automatically adjusted to reflect all benefits paid from your account.

What does pre-tax mean?

Deductions to fund your account(s) are taken from your paycheck before federal, state*, and FICA taxes are applied to your pay. Your savings are returned in each paycheck, because you automatically pay fewer taxes. With a Health Care Account, you will not need to do anything on your tax return or fill out any IRS forms. If you participate in the Dependent Care Account, the amount you contribute for Dependent care will be reported on your W-2 form; you will need to complete Federal Form 2441 (and identify your provider just as you would if you were taking the dependent care tax credit) and whatever state forms are required. **This information should not be construed as tax advice. Check with your advisor regarding your personal tax situation.**

*State taxes do apply in New Jersey and some other states; check with your tax advisor.

What are the benefit limits for the Health Care FSA?

Minimum and maximum benefits from pre-tax Employee contributions allowed under the Plan per Plan Year. The minium annual contribution limit is $500. The maximum is the allowable amount per federal guidelines. Please see the Benefits Guide.

How do I access benefits?

- **Health Care Card** – A Participant can use the NetBenefits AccessCard® to pay for Health Care Expenses directly from his HC FSA. The Employee may be required to submit a detailed receipt to show that the card was used for eligible expenses.
- **File A Claim to Pay My Provider** – A Participant can request that payment be made from his HC FSA or DC FSA and sent directly to the provider indicated by the Participant at the time of request. You can submit the claim directly on www.netbenefits.com or via the Reimbursement Request Form found in the Tools & Support tab on NetBenefits

- **File A Claim to Reimburse Myself** – When filing a claim, ensure the expense has been paid out of pocket.You can submit the claim directly on www.netbenefits.com or via the Reimbursement Request Form found in the Tools & Support tab on NetBenefits.

How do I get a Health Care Card?

When you enroll, you will automatically be sent a NetBenefits AccessCard® within a few weeks of the start of your Coverage Period. You may request additional cards for use by any of your eligible Dependents. You will be provided with instructions on how to activate and use your card. Be sure to keep your receipts for any services or products purchased with each card issued from your account.

Why should I save my receipts when I use the Health Care Card?

You may be required to submit a detailed receipt (not the credit card like receipt, but one that describes the product or service paid for to show that the card was used for eligible expenses. If you are not able to show the card was used for eligible expenses, you will be required to repay the Plan in the amount of the card transaction. If you fail to repay the Plan, collection of past due amounts will be deducted from future reimbursement checks and/or be subject to other collection policies. Card privileges may be revoked at any time. Use of the card that exceeds the amount elected less amounts previously paid is your responsibility and must be paid back to the Plan.

If the plan administrator (Fidelity) does not receive and process documentation within 100 days after your card transaction, your account will be inactivated and placed in a temporary hold status. You will be asked to send appropriate documentation or reimburse your account. Your account will be reactivated within one business day of processing your documentation or repayment.

What expenses are eligible to be paid from a Spending Account?

Any eligible expense that you, your Spouse, a Qualifying Child, or a Qualifying Relative (see questions 7 and 8) incur during your Coverage Period in the Plan Year may be paid from a Spending Account. Expenses are incurred when you receive the service, without regard for when you pay for the service. In fact, expenses do not have to be paid in order to be eligible.

You cannot use your account to pay for expenses you received before or after your Coverage Period, during another Plan Year, or for expenses you will receive in the future (even if you had to pay for them in advance).

> Example 1: You have an appointment to get a dental crown on January 5th. Your dentist requires you to pay 100% of your out-of-pocket costs (after determining how much your dental plan will cover) two weeks prior to your appointment, by December 21st.
>
> - You cannot use your Health Care Account to pay for the advance payment on December 21st because you have not yet received the service.
> - You can use your Health Care Account to get reimbursed for the payment you made in December by filing a claim for reimbursement after you get your crown on January 5th.
> - This expense is eligible to be paid out of the Health Care Account that covered you on January 5th (not the account that covered you in December when you made the payment, if different).

Example 2: You did not have a Health Care Account last year but have an account as of January 1st of this year. You just received a bill from your dentist for services you received last year.

- You cannot use your Health Care Account to pay for expenses incurred prior to your Coverage Period, which began on January 1st of this year.
- Since these expenses were incurred last year, when you did not have a Health Care Account, they are not eligible to be paid from your Health Care Account this year.
- If you had a Health Care Account last year, then these expenses would be eligible to be paid from last year's account.

What expenses are eligible for the Health Care Account?

Eligible Health Care Expenses include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The Health Care Expenses must be primarily to alleviate or prevent a physical or mental defect or illness. It can include amounts for cosmetic surgery only if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. Eligible Health Care Expenses can include products as well as services. This includes prescription drugs (and over-the-counter products and devices with a prescription). Ineligible expenses include products and services for cosmetic purposes, even if prescribed by a doctor (such as hair growth and wrinkle treatments). In addition, an expense is not eligible if it is not for "medical care," or if it is merely for the beneficial health of you and your eligible Dependents (for example, vitamins or nutritional supplements that are not taken to treat a specific medical condition). Per IRS regulations, health insurance premiums of any kind are not reimbursable under the Health Care Account. For a complete list of eligible Health Care Expenses, go to www.irs.gov.

Whether an expense is for "medical care" as defined by Code Section 213(d) is within the sole discretion of the Administrator. You may, in the discretion of the third party administrator or the Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition.

If you have opted for the HSA-Compatible or Limited Use Health Care Account, then only those eligible dental and vision expenses may be paid under the Plan while your limited coverage is effective.

Please note: The IRS determines what expenses you can pay for. For general medical expense information, see IRS Publication 502 at http://www.irs.gov/pub/irs-pdf/p502.pdf.

What if the eligible expenses I incur during the Plan Year are less than the annual amount I have elected under each of the Spending Accounts?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual eligible expenses you have incurred, and the annual coverage level you have elected and paid for. Any amount allocated to a HC FSA or a DC FSA shall be forfeited by the Participant if it has not been applied to provide the elected benefit for the Plan Year within the run-out period as outlined in the Plan Information Section. Amounts so forfeited shall be applied in a manner consistent with applicable rules and regulations.

What is the maximum annual dependent care reimbursement that I may elect under the DC FSA?

The annual amount cannot exceed the maximum dependent care reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently the ***lesser*** of $7,500 or the amount set forth in the Key Plan Information Section per calendar year if you:

- Are married and file a joint return;
- Are married but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the DC FSA; or
- Are single.

If you are married and reside together, but file a separate federal income tax return, the maximum dependent care reimbursement that you may elect is $3,750. In addition, the amount of reimbursement that you receive cannot exceed the lesser of the earned income (as defined in Code Section 32) of you or your Spouse. Your Spouse will be deemed to have earned income of $250 ($500 if you have two or more Qualifying Individuals), for each month in which your Spouse is (i) physically or mentally incapable of caring for himself, or (ii) a full-time student (as defined by Code Section 21).

What expenses are eligible for the Dependent Care Account?

Eligible Dependent Care Expenses include amounts paid for the care of eligible Dependents that allow you (and your Spouse, if you are married) to work or look for work. Your Spouse is treated as working during any month he or she is a full-time student or is physically or mentally not able to care for him or herself. Whether your expenses allow you to work or look for work depends on the facts. For example, the cost of a baby sitter while you and your Spouse go out to eat after work is not normally a work-related expense. Expenses are not considered work-related merely because you had them while you were working. They must enable you to be gainfully employed. For a complete list of eligible Dependent Care Expenses, go to www.irs.gov.

The IRS determines what expenses you can pay for. For child and dependent care expenses, see IRS Publication 503 at https://www.irs.gov/pub/irs-pdf/p503.pdf.

Who are eligible Dependents for the Health Care Account?

You can use your Health Care Account to pay for Health Care Expenses incurred by any of the following people – even if they are not covered by your Employer's health plan:

- Yourself
- Your Spouse
- Your Qualifying Child*
- Your Qualifying Relative*

* Special rules allow a Dependent to be eligible for this Plan even when that Dependent does not qualify to be claimed as your tax dependent on your tax return form. For more information, see IRS Publication 503 at https://www.irs.gov/pub/irs-pdf/p503.pdf.

Who are eligible Dependents for the Dependent Care Account?

You can use your Dependent Care Account to pay for work-related* care for your eligible Dependents:

- Your Qualifying Child* – under the age of 13
- Your Spouse, or a Qualifying Child or Relative* – who is physically or mentally incapable of self care

For more information on eligible dependents, see IRS Publication 502 and 969 at https://www.irs.gov.

Are there disadvantages to participating in a Spending Account?

There are some potential disadvantages:

- First, your election is generally set for the year. If you have a qualified change and request a change in enrollment in a timely manner, you may qualify to change your election amount during the middle of the Plan Year. So, planning is important.
- Second, you need to be sure to spend your entire election amount during your Coverage Period. You have through the end of your run-out period to file claims against your account. Any balance remaining after that time is required to be forfeited and cannot be rolled over.
- Third, no asset is set aside in a trust or any account at any financial institution on your behalf. Amounts deducted from your pay become the general assets of the Employer. All payments are made by the Employer.
- Fourth, because you do not contribute to FICA and Medicare, your Social Security or Medicare and any other compensation-based benefits may be lower.

Can I take the Dependent Care Tax Credit and have a Dependent Care Account?

You may not take advantage of the tax credit and the Dependent Care Account for the same expenses. If you use the tax credit, every dollar of your salary you have put into a Dependent Care Account reduces by one dollar the expenses you may claim for the tax credit. Check with your advisor regarding your personal situation.

Who is Fidelity?

Fidelity was hired by the Employer to process the transactions and claims for this program. If you have questions about your account balances and any transaction, you can review your account information online at www.netbenefits.com. Simply enter your user name and password or select Register As A New User to complete the simple online registration process to access your account online.

How do I enroll for a Spending Account?

If this is your first enrollment, you may be able to enter the Plan during the initial enrollment period and become a Participant on the effective date (see the Plan Information Section for more details). Each year thereafter you are eligible to participate, you can enroll during annual enrollment. Simply follow the instructions provided to you. You can enroll for one or both accounts. To enroll, you are required to provide an election amount for the Health Care Account and a separate amount for the Dependent Care Account, if desired. If you enroll for both accounts, please note that the accounts are separate and your balances cannot be transferred between accounts. Elections for participation in either or both of the

Spending Accounts must be made by enrolling annually prior to the beginning of each Plan Year—no deemed elections shall occur under these Plans.

What is a qualified change?

For the Health Care Account:

- Change in your legal marital status (marriage, legal separation, divorce, annulment, or death of Spouse)
- Change in the number of your Dependents (birth, adoption, placement for adoption, or death)
- Change in employment status, if eligibility is affected (yours, your Spouse's, or your Dependent's; termination, commencement of employment, strike or lockout, start or return from unpaid leave, change in worksite, change in eligibility status)
- Dependent satisfies or ceases to satisfy eligibility requirements

For the Dependent Care Account:

- All of the above
- Change in coverage (change in provider, cost, hours). (No change is allowed, however, when the cost change is imposed by the dependent care provider who is also a relative.)

Additionally, the Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the IRS), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Am I allowed to change my election outside of annual enrollment?

Qualified changes are allowed per federal guidelines. Changes due to a qualifying life event have to be initiated by the employee within 31 days of the event and are effective the first of the month following request of enrollment change (with exception for changes resulting from birth, adoption or placement for adoption – which will be made as of the date of the qualifying event in accordance with HIPAA).

Coverage ends the last day of the month following request to cancel enrollment due to a qualifying life event.

How do I file an appeal if my claim was wrongfully denied?

You will be notified in writing if a claim you submit is denied. An explanation will be provided to you, including a description of any required but missing documentation. You can resubmit the claim with the required information without filing a formal appeal.

You may file an appeal within 180 days of the date you receive notice that your claim was denied (or, if applicable, within 180 days after the date on which such denial is considered to have occurred), by submitting a letter describing the circumstances along with a copy of the denied claim, all documentation used to substantiate the claim, the denial letter, and any further documentation to support your appeal to: Fidelity@service.healthaccountservices.com or contact their office at 833-299-5089.

A final determination will be communicated to you in writing within 60 days from receipt of your appeal.

What do I need to file Dependent care claims?

In addition to a signed and completed claim form, you will need a receipt verifying the amount of your expenses. You will also need to provide the Social Security or Tax ID number of your provider (or certify that your provider is tax-exempt).

How long do I have to submit claims?

Claims must be submitted no later than the claims deadline indicated at the front of this document. Eligible expenses are those incurred during your Coverage Period during the Plan Year. Claim forms can be downloaded at www.netbenefits.com. Simply enter your user name and password, or select Register As A New User to complete the simple online registration process to access your account online.

What happens to unclaimed Spending Account reimbursements?

Any health care or dependent care reimbursement benefit payments that are unclaimed (i.e., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the eligible Health or Dependent Care Expense was incurred shall be forfeited.

Can I transfer my balance to the other account?

No. The Health Care and Dependent Care Accounts are two separate accounts. You cannot transfer money between the two, or be reimbursed for claims that are not consistent with the requirements for each account.

How do I get account information?

Go to www.netbenefits.com. Enter your user name and password, or select Register As A New User to complete the simple online registration process to access your account.

What happens if I retire or terminate employment with the Employer mid-year?

Your coverage will end per the Plan Information at the beginning of this document. You may continue to submit claims for reimbursement of expenses incurred prior to the end of your Coverage Period as indicated in the Plan Information. Expenses incurred after your Coverage Period are not eligible for reimbursement. You will be notified if you are eligible to continue participating in the Health Care Account under COBRA. Your Health Care Card will be disabled on the day your coverage ends. The only way to access your account when your Health Care Card is disabled, is to submit a claim for reimbursement of your expenses.

If I am called to uniformed service, can I continue coverage under the Plan?

If you are absent from employment with your Employer as a result of uniformed service under USERRA (the Uniformed Services Employment and Reemployment Rights Act of 1994), you may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months, or until you fail to apply for reinstatement, or return to employment with your Employer within the period prescribed by USERRA. You are responsible for making the required premium payments and contributions under the Plan during this period. The Plan Administrator can provide you with information regarding how premium payments and contributions will be made. If your coverage under the Plan is terminated due to

being in uniformed service, but are later reinstated, you will not be subject to a new waiting period before entering the Plan, provided that this requirement would not have been imposed if coverage had not been terminated as a result of the uniformed service.

What if I need more information?

Check with your benefits manager. In addition, you have the right to:

- Examine, without charge, at the Employer's office, all Plan documents.
- Obtain copies of all Plan documents and other Plan information upon written request to the Employer. The Employer may make a reasonable charge for the copies.

How long will this program last?

While the Employer has no intention of changing or ending this program, the Plan may be amended or terminated at any time by the Employer in any manner that it determines.