

**SUMMARY OF MATERIAL MODIFICATION IN COVERED SERVICES OR BENEFITS  
TO THE  
THE ALEXANDER GROUP, INC  
FSA MEDICAL PLAN**

To all Participants of the FSA Medical Plan.

This notice, called a "Summary of Material Modification in Covered Services or Benefits," advises you of changes in the information present in your Summary Plan Description (sometimes called an "SPD") with respect to the Medical Plan. Please do three things:

- (1) Read the Notice and, if you have any questions, contact the Plan Administrator,
- (2) Keep this notice with your Summary Plan Description, and
- (3) Mark the sections of your Summary Plan Description that are affected by this notice so that when you look at the section of your Summary Plan Description, you will be reminded that the changes described in this notice has occurred.

The Employer desires to utilize its specifically reserved right to modify or amend the Summary Plan Description (SPD). **Effective January 1, 2018**, the SPD is modified as follows:

***Contributions- Page 5***

**The maximum employee contribution is increasing to \$2,650.**

IN WITNESS WHEREOF, the Employer has executed this Amendment on the 17  
day of November, 2017.

THE ALEXANDER GROUP, INC

By: [Signature]

Title: HR Administrator

Date: 11/17/17

**FLEXIBLE SPENDING ACCOUNT PLAN  
for  
THE ALEXANDER GROUP, INC.  
EFFECTIVE JANUARY 1, 2015**

# Flexible Spending Account Plan

## NOTICE TO EMPLOYEES

This booklet describes the Employer-sponsored Flexible Spending Account Plan ("Plan") as of JANUARY 1, 2015.

THE ALEXANDER GROUP, INC. has entered into an agreement with HealthEZ under which HealthEZ will process reimbursements and provide certain other administrative services to the Plan.

HealthEZ does not insure the benefits described in this booklet.

THIS FLEXIBLE SPENDING PLAN DOCUMENT, made by THE ALEXANDER GROUP, INC. (the "Company" or the "Plan Sponsor") as of JANUARY 1, 2015, hereby sets forth the provisions of THE ALEXANDER GROUP, INC. Flexible Spending Plan (the "Plan").

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

THE ALEXANDER GROUP, INC.

By: Deborah Stanish

Name: Deborah Stanish

Title: Exec Director Ops

Date: 2/23/2015

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## **PLAN HIGHLIGHTS**

Under the Plan, you can elect to establish two Flexible Spending Accounts (“FSAs”) which you fund with before-tax contributions under a Section 125 Cafeteria Plan from your salary, and which you then use to reimburse yourself for Eligible Expenses.

The Health Care Spending Account (“HCSA”) is for reimbursement for eligible medical expenses incurred by your legal spouse (as determined in accordance with state law to the extent consistent with the federal Defense of Marriage Act), any individual who would qualify as a dependent of yours under Code Section 105(b), and any child for whom you are required to provide health coverage pursuant to a Qualified Medical Child Support Order. Also, a child of parents who are divorced, legally separated or who live apart at all times during the last six months of the calendar year is considered to be a dependent of both parents provided the child lives with one or both parents for more than half of the calendar year and both parents together provide over half of the child’s support.

The Dependent Care Spending Account (“DCSA”) is for reimbursement of eligible dependent care expenses, such as child or adult day care.

You can elect to participate in the HCSA, the DCSA, or both.

## **WHO IS ELIGIBLE AND HOW TO START YOUR FLEXIBLE SPENDING ACCOUNT**

### **Who is Eligible**

Regular full-time, year round employees of the Plan Sponsor who are scheduled to work at his or her job at least 30 hours per week are eligible to participate in the Plan.

### **Limits on Certain Employees**

If you are a highly compensated employee or an owner of the Company, federal law may impose limits on your eligibility to participate in the Plan and/or the benefits you may receive from the Plan.

### **When You are Eligible to Enroll**

You are eligible to participate in the Plan the first of the month following date of hire. You can enroll the month prior to your eligibility date via our online enrollment procedures or by completing a paper enrollment application. If you do not participate during this time, you must wait until the next annual enrollment period to elect to participate in the Plan, unless you have experienced a qualified change in status (See the Changing Your Contribution Amounts section below). You will need to enroll each year, even if you enrolled in the Plan the year before.

### **How to Enroll**

You elect to participate in the Plan by completing the online enrollment process or by completing a paper enrollment application. You must specify the amount of before-tax dollars you wish to contribute to the HCSA, the DCSA, or both.

## CONTRIBUTIONS

Each year, you must decide the amount of before-tax dollars you want to contribute to the accounts. You may contribute to the HCSA or DCSA, or both, however, amounts contributed to one account cannot be used to reimburse expenses under the other account.

You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as “Eligible Expenses”, for the upcoming Plan Year because IRS regulations require that you forfeit any unused funds remaining in either account after the end of the Plan Year. You have 90 days after the end of the plan year to submit a claim for expenses incurred the previous year.

For the Health Care Spending Account, you may elect to contribute between \$130 and \$2,550 per Plan year.

For the Dependent Care Spending Account, you may elect to contribute between \$130 and \$5,000 per Plan year, or if you are married and filing separately for federal income tax purposes, you may elect to contribute up to \$2,500 a year.

## CHANGING YOUR CONTRIBUTION AMOUNTS

IRS regulations do not permit you to stop or change the amount you contribute to a flexible spending account during the Plan year, unless you meet one of the following conditions:

- A. With regard to both a HCSA and a DCSA, one of the following changes in status occurs and as long as enrollment occurs within 30 days of the change in status, contribution changes are effective immediately after the change in status:
  - 1) An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment.
  - 2) An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
  - 3) An event that results in a change in the employment status of you, your spouse or dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence, and a change in work site.
  - 4) An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements for dependent group health coverage or coverage under the DCSA due to the attainment of age, student status or any similar circumstances, as provided under the group health plan under which you receive coverage or under the DCSA, as applicable.
- B. For individuals who participate in a HCSA, the following additional events will enable you to change your election:
  - 1) If you become entitled to Medicare or Medicaid, you may elect to revoke your HCSA coverage.
  - 2) If the FSA Plan Sponsor receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the FSA Plan Administrator may:
    - 3) If the order requires you to provide coverage for the child under the HCSA, change your election to provide coverage for that child.
    - 4) If the order requires your former spouse to provide coverage, permit you to cancel your child's coverage under the HCSA.

- C. For individuals who participate in a DCSA, the following events, in addition to those in above will enable you to change your election:
- 1) A change in your dependent care provider. If your dependent care provider significantly increases or decreases the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.
  - 2) The above rules are intended to be consistent with the IRS regulations under Section 125 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.
  - 3) Any new election hereunder must be on account of and correspond with the change in status event. As used herein, "dependent" means a tax dependent under Section 152 of the Internal Revenue Code.
  - 4) Changes in contribution amounts made during the Plan Year are effective immediately following the change in status.

## HEALTH CARE SPENDING ACCOUNT

### Eligible Expenses

To be eligible for reimbursement from your HCSA, the health care expenses must be all of the following:

- 1) Incurred for medical care, defined in Section 213 (d) of the IRC as amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body;
- 2) Incurred while you are participating in the Plan;
- 3) Incurred during the Plan Year; and
- 4) Not reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your HCSA. Generally, Eligible Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) and include any deductible, copayment and coinsurance amounts.

Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office or IRS website [www.irs.gov](http://www.irs.gov). **However, there are certain expenses which are listed as deductible in IRS Publication 502, but which cannot be reimbursed by the HCSA because of IRS rules (e.g., insurance premiums).**

- **Eligible Medical Expenses.**
- **Vision Expenses.**
- **Hearing Expenses.**
- **Dental Expenses.**
- **Prescription Drugs.**

## **Ineligible Expenses**

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements and toiletries such as toothpaste, etc.)

In addition, as with any other expense reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan, health expenses reimbursed through your HCSA can not be claimed as deductions on your income tax return.

## **DEPENDENT CARE SPENDING ACCOUNT**

### **Eligible Expenses**

Eligible Expenses that can be reimbursed from your DCSA are expenses incurred for dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you cannot use a DCSA unless your spouse is physically or mentally incapable of caring for himself or herself, or is a full-time student for at least five months during the Plan Year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of \$250 (as adjusted from time to time) if you have one dependent, or \$500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- 1) A dependent under federal tax law who is a child under age 13; or
- 2) A spouse or dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such spouse or dependent lives in your home for more than one-half of the year.

**Eligible Expenses:** Include, but are not limited to, the following expenses if not otherwise excluded:

- 1) Expenses for care at a day care center that complies with all applicable state and local regulations.
- 2) Expenses for care provided by a housekeeper, babysitter or other person in your home.
- 3) Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and are not your dependent under federal tax law.
- 4) Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

**Ineligible Expenses:** The partial list below includes examples of expenses that are not eligible for reimbursement:

- 1) All cost associated with sending a child to an overnight camp, even if the camp specializes in a particular activity, such as computers or soccer.
- 2) The cost of getting a qualifying person from your home to the care location and back, or from the care location to school and back, is not considered a work-related expense. This includes the costs of bus, subway, taxi, or private car. Also, if you pay the transportation cost for the care provider to come to your home, you cannot count this cost as a work-related expense.

### **Dependent Care Tax Credit vs. Dependent Care Spending Account**

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care Flexible Spending Account. In other words, you cannot use expenses reimbursed through the DCSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the DCSA.

## **REQUESTING A REIMBURSEMENT FROM YOUR FLEXIBLE SPENDING ACCOUNT**

To be reimbursed from your account, simply submit a reimbursement form, called a request for withdrawal, for the Eligible Expenses that have been incurred.

For reimbursement from your HCSA, you must include proof of the expenses incurred. Proof can include a bill, invoice or an Explanation of Benefits (EOB) from any plan that provides health benefits under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical and dental plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental plans.

For reimbursement from your DCSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.

Only expenses which are incurred while you are a participant in the Plan may be reimbursed from a Flexible Spending Account. In addition, expenses which are incurred during one Plan Year cannot be reimbursed during another Plan Year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as daily. You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least \$25, except for reimbursement with respect to the last month of the Calendar Year. Amounts below \$25 will be accumulated and processed with future payments.

If you have established a HCSA, your total annual contribution is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a DCSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

For expenses incurred during the Plan Year, requests for withdrawal will be accepted and processed through March of the following year.

## **FORFEITURES**

### **Plan Year/Termination**

In accordance with IRS regulations, amounts contributed to your HCSA or DCSA during the Plan Year but remaining in your account at the end of the processing period cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan Year. These amounts are forfeited and applied as directed by the Employer in accordance with the Plan.

Effective January 1, if you cease to be a participant in the cafeteria plan (because of termination of employment or other reason) you may continue to be reimbursed for eligible dependent care expenses through the end of the Plan Year (or grace period if applicable).

### **Grace Period**

However, the unused balance in your account that remains at the end of a Plan Year may be used for expense that you incur during the grace period. The grace period is the 2 ½ month period after the end of the Plan Year (March 15<sup>th</sup>). If there is a Grace Period, any qualified medical expenses incurred in that period can be paid from any amounts left in the account at the end of the previous year. Your employer is not permitted to refund any part of the balance to you. You will have until April 30<sup>th</sup> to submit only the claims that were incurred during the grace period.

### **Claim Denial Process**

If your claim is denied for reimbursement, you will receive a written notice from HealthEZ within 30 days of receipt of the claim, as long as all needed information was provided with the claim. HealthEZ will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame and the claim is denied, HealthEZ will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will explain the reason for the denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

### **Questions and Appeals**

If you have a question or concern about a claim reimbursement determination, you may informally contact a HealthEZ Customer Service representative before requesting a formal appeal. You may contact Customer Service at 844-855-0620. If the Customer Service representative cannot resolve the issue to your satisfaction, you may request a formal appeal as described below.

If you wish to request a formal appeal of a denied claim for reimbursement, you should submit your request in writing to the following address:

**HealthEZ  
7201 West 78<sup>th</sup> Street, Suite 100  
Bloomington, MN 55439  
800-948-5888**

You should include your name and a description of the claim determination that you are appealing, the reason you believe your claim should be reimbursed, and any written information to support your appeal.

Your first appeal request must be submitted in writing to HealthEZ within 180 days after you receive the denial.

A qualified individual who was not involved in the initial benefit decision being appealed will be designated to decide the appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for reimbursement.

The first level appeal will be conducted and you will be notified by HealthEZ of the decision in writing within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Plan Sponsor. Your second level appeal request must be submitted in writing to the Plan Sponsor within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by the Plan Sponsor of the decision in writing within 30 days from receipt of a request for a second level appeal. The Plan Sponsor has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

## WHEN PARTICIPATION ENDS

You will cease to participate in the Plan as of the earlier of:

- 1) The date on which the Plan terminates;
- 2) The date you cease to be an eligible employee; or
- 3) The date you fail to make a required contribution under the terms of the Plan.

### **Health Care Spending Account**

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan Year of termination, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before March 31st of the year after the Plan Year of termination.

Your Employer offers Consolidated Omnibus Budget Reconciliation Act ("COBRA") for your Health Care Spending Account Plan. Please see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)" for more information.

### **What happens if I take a leave of absence?**

If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Package Options providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Part 125, FMLA, and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Package Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.

If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Package Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Package Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Package Option offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

**What happens if I terminate employment (or cease to be eligible) and then am rehired (become eligible again) during the same Plan Year?**

If you terminate your employment or you cease to be eligible for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then you are rehired or again become eligible within 30 days or less of the date of a termination of employment or cessation of eligibility, then you will be reinstated in the Plan (assuming you otherwise satisfy the eligibility requirements of the Plan) with the same elections you had before termination subject to any restrictions imposed under the applicable Benefit Package Options). If you are rehired or again become eligible more than 30 days following termination of employment or cessation of eligibility and you are otherwise eligible to participate in the Plan, then you may make new elections.

## **OPTIONAL CONTINUATION COVERAGE UNDER YOUR HEALTH CARE SPENDING ACCOUNT (COBRA)**

This optional continuation coverage only applies if it has been made available by Group Name. Group Name may be required to offer this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See Group Name to find out if and how this continuation coverage applies.

In no event will HealthEZ be obligated to provide continuation coverage to a participant if Group Name or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the participant in a timely manner of the right to elect continuation coverage and notifying HealthEZ in a timely manner of the participant's election of continuation coverage.

In general, COBRA continuation coverage must be offered with respect to a participant's HCSA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a participant who experiences a qualifying event and continuation coverage is elected by the participant, such coverage will cease at the end of the Plan Year in which the qualifying event occurs and cannot be continued into the next Plan Year. Such coverage will cease at the end of the Plan year or until participant ceases to be enrolled in COBRA. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis, on a uniform and consistent basis.

HealthEZ is not THE ALEXANDER GROUP, INC. designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

**Dependent Care Spending Account**

You may submit claims for the Eligible Expenses you have incurred at any time during that Plan Year, including Eligible Expenses incurred after your termination date, against what is in your DSCA when you leave employment. Any such claims must be submitted on or before March 31st of the next Plan Year.

## ERISA STATEMENT

**Name of Plan:** THE ALEXANDER GROUP, INC. FSA PLAN

**Name and Address of Plan Sponsor and Named Fiduciary:**

THE ALEXANDER GROUP, INC.  
8155 East Indian Bend Road #111  
Scottsdale, AZ 85250

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

**Claims Administrator:** HealthEZ

**Employer Identification Number (EIN):** 13-3248641  
**IRS Plan Number:** 501

**Effective Date of Plan:** January 1, 2015

**Type of Plan:** Flexible Spending Account/Section 125 Cafeteria Plan

**Name and business address of Plan Administrator:**

THE ALEXANDER GROUP, INC.  
8155 East Indian Bend Road #111  
Scottsdale, AZ 85250

**Type of Administration of the Plan:** The Plan is administered on behalf of the Plan Administrator by HealthEZ. HealthEZ provides administrative services for the Plan including claims processing, claims payment, and handling appeals.

**Person designated as agent for service of legal process:**  
Plan Sponsor as shown above.

**Sources of contributions and funding under the Plan:**  
The Plan is funded by general assets of the Plan Sponsor based on the salary reduction elections made by participating Employees.

**Method of calculating the amount of contribution:** Employee contributions to the Plan are determined by each Employee's salary reduction election based on the Plan limitations as determined by the Plan Sponsor.

**Plan Year:** Plan Year shall be a 12 month period; Calendar

**Plan Amendment and Termination:** Although the Plan Sponsor currently intends to continue the benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or amendment to or termination of the

Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or amendments to the Plan.

Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Sponsor, including this Summary Plan Description.

Participant's rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims for reimbursement or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

## **Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights**

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:

### **Receive Information about Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specific locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for 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 the summary annual report.

### **Continue Group Health Care Coverage**

Continue health coverage for yourself, spouse or 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 this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, free of charge, from your group health plan or health insurance issuer when you lose coverage

under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. You may request a certificate of creditable coverage by contacting HealthEZ.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon people who are responsible for the operation of the employee benefit 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, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this is 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 you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, 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 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 the costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

### **Assistance with Your Questions**

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

# HIPAA PRIVACY RIGHTS

**This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.**

HealthEZ is committed to maintaining and protecting the confidentiality of our members' personal and sensitive information. We are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information, and to provide you this Notice about our policies, safeguards and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice.

## **How We Protect Your Privacy**

HealthEZ will not disclose confidential information without your authorization unless it is necessary to:

- 1) Provide your health benefits
- 2) Administer your benefit plan
- 3) Support the programs or services of HealthEZ
- 4) Comply with applicable laws

When we need to disclose individually identifiable information, we will follow the policies described in this Notice to protect your confidentiality.

HealthEZ, 7201 W 78<sup>th</sup> Street, Bloomington, MN maintains confidential information, and has procedures for accessing, labeling, and storing confidential records. Access to our facilities is limited to authorized personnel. HealthEZ restricts internal access to your confidential information to HealthEZ employees who need to know that information to conduct our business. HealthEZ trains its employees on policies and procedures designed to protect your privacy. Our Privacy Officer monitors how we follow those policies and procedures, and educates our organization on this topic.

## **How We Use and Disclose Your Confidential Information**

We will not use your confidential information or disclose it to others without your authorization, except for the following purposes:

- **Treatment** – We may disclose your confidential information to your health care provider for its provision, coordination or management of your health care and related services.
- **Payment** – We may use and disclose your confidential information to obtain payment of premiums for your coverage and to determine and fulfill our responsibility to provide your health plan benefits – for example, to make coverage determinations, administer claims and coordinate benefits with other coverage that you might

have. We may also disclose your confidential information to another health plan or a health care provider for its payment

- **Activities** – for example, for the other health plan to determine your eligibility or coverage, or for the health care provider to obtain payment for health care services provided to you.

- **Health Care Operations** – We may use and disclose your confidential information for our health care operations – for example, to provide customer service and conduct quality assessment and improvement activities. We may also disclose your confidential information to another health plan or a provider who has a relationship with you for the above mentioned activities.

- **Disclosures to Your Employer as Sponsor of Your Health Plan** – We may disclose your confidential information to your employer or a company acting on your employer's behalf, so that it can monitor, audit and otherwise administer the employee health benefit plan in which you participate. Your employer is not permitted to use the confidential information we disclose for any purpose other than administration of your health benefit plan.

- **Disclosures to HealthEZ Vendors and Accreditation Organizations** – We may disclose your confidential information to companies with whom we contract, if they need it to perform the services we've requested. When we enter into these types of arrangements, we obtain a written agreement to protect your confidential information.

- **Public Health Activities** – We may disclose your confidential information for the following public health activities and purposes: To report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury, or disability;

- 1) To report child abuse or neglect to a government authority that is authorized by law to receive such reports;
- 2) To report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity;
- 3) To alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.

- **Health Oversight Activities** – We may disclose your confidential information to a government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefits programs, such as Medicare or Medicaid, or other regulatory programs that need health information to determine compliance.

- **For Research** – We may disclose your confidential information for research purposes, subject to strict legal restrictions.

- **To Comply with the Law** – We may use and disclose your confidential information to comply with the law.

- **Judicial and Administrative Proceedings** – We may disclose your confidential information in a judicial or administrative proceeding or in response to a legal order.
- **Law Enforcement Officials** – We may disclose your confidential information to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- **Health or Safety** – We may disclose your confidential information to prevent or lessen a serious and imminent threat to your health or safety, or the health and safety of the general public.
- **Government Functions** – We may disclose your confidential information to various departments of the government.
- **Workers' Compensation** – We may disclose your confidential information when necessary to comply with Workers' Compensation laws.

#### **Uses and Disclosures with Your Written Authorization**

We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice, without your written authorization. For example, we will not supply your confidential information to another company for marketing purposes, or to a potential employer with whom you are seeking employment, without your signed, written authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not retroactively.

#### **Your Individual Rights**

**Right to Request Additional Restrictions** – You may request restrictions on our use and disclosure of your confidential information for the treatment, payment, and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction.

**Right to Receive Confidential Communications** – You may ask to receive communications of your confidential information from us by alternative means of communication or at alternative locations. While we will consider all reasonable requests carefully, we are not required to agree to all requests.

#### **Right to Inspect and Copy Your Confidential Information –**

You may ask to inspect or to obtain a copy of your confidential information that is included in certain records that we maintain. Under limited circumstances, we may deny you access to a portion of your records. If you request copies, we may charge you copying and mailing costs.

**Right to Amend Your Records** – You have the right to ask us to amend your confidential information that is contained in our records. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If your doctor or another person created the information that you want to change, you should ask that person to amend the information.

***Right to Receive an Accounting of Disclosures*** – Upon request, you may obtain an accounting of disclosures we have made of your confidential information. The accounting that we provide will not include disclosures made before April 14, 2004, disclosures made for treatment, payment, or health care operations, disclosures made earlier than six years before the date of your request, and certain other disclosures that are exempted by law. If you request an accounting more than once during any 12-month period, we will charge you a reasonable fee for each accounting statement after the first one.

**For More Information or Complaints**

If you want more information about your privacy rights, do not understand your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your confidential information, you may contact our Privacy Officer. You may also file written complaints with the Secretary of the U.S. Department of Health and Human Services. Please call our Privacy Officer to obtain the correct address for the Secretary. We will not take any action against you if you file a complaint with the Secretary or us.

You may contact our Privacy Officer at:

Privacy Officer  
HealthEZ  
7201 W. 78<sup>th</sup> Street  
Suite 100  
Bloomington, MN 55439  
952-896-1200

We may change the terms of this Notice at any time. If we change this Notice, we may make the new Notice terms effective for all your confidential information that we maintain, including any information we created or received before we issued the new notice. If we change this Notice, we will send you the new notice if you are enrolled in an HealthEZ benefit plan at that time.