

The Waterfront Beach Resort

Flexible Spending Plan

Medical FSA Summary

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INTRODUCTION

The Waterfront Beach Resort's Flexible Benefit Plan (the "Plan") permits Eligible Employees to choose to pay for certain benefits on a pre-tax basis.

This *Summary* describes the Medical Flexible Spending Account ("Company-sponsored") Benefit Option under the Plan. Through the Medical FSA, you can pay Medical Expenses not covered by insurance for yourself and eligible family members on a pre-tax basis. This will generally result in a tax savings and increase your spendable income.

The tax benefit you experience will depend on the benefits you elect, as well as other factors that affect the amount of taxes you pay. Although participating in the Plan can provide significant tax advantages, there may be tax disadvantages to participating in the Plan based on your particular situation. You may wish to consult with your tax advisor.

DETAILS REGARDING THE MEDICAL FSA BENEFIT

- (a) **Medical expenses eligible for reimbursement:** To be eligible for reimbursement, an expense must be for medical care provided to diagnose, treat, or prevent disease or for sickness or injury and must be included on the list of eligible medical expenses for this Benefit Option.
- (b) **Employee Elections: The maximum annual contribution for this benefit is the maximum allowed by the IRS. Note that salary reduction amounts from the last paycheck of the Plan Year may be used to pay for the first month of benefits elected for the next Plan Year.**

- (c) **Employer Elections:**

The employer may contribute up to \$500 to all eligible employees to enroll in their health plan without an employee contributing.

Employer may match dollar-for-dollar contributions (up to maximum allowed contribution determined by law) as long as the employee contributes the same amount. Employer contributions do not count toward the employee's maximum annual contribution.

When contributing an amount over \$500, an employer's contribution cannot exceed the employee's election. For example, if the employee is contributing \$1,000, the maximum employer contribution can only be \$1,000 to the employee's FSA. When contributing an amount over \$500, an employer's contribution cannot exceed the employee's election.

- (d) **Expenses cannot be reimbursed from any other source, including tax credits or tax deductions:** Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud and you personally will be responsible

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for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.

- (e) **Limitations for HSA and Medical FSA combination:** If you elect to participate in both the HSA and the Medical FSA benefits under this Plan, your Medical FSA is automatically limited to reimbursement of the following HSA-Compatible expenses: Vision and Dental; Post Deductible Medical. You may also choose to participate in an HSA-Compatible Medical FSA to maintain your eligibility and/or the eligibility of your spouse to participate in an HSA outside of this Plan. If you have not elected HSA coverage under this Plan, however, you must notify your Employer that you wish to participate in an HSA-Compatible Medical FSA.

ELIGIBLE EMPLOYEES

Only eligible employees may participate. You are eligible if you are:

- Employed by the company or a participating employer
- Regularly scheduled to work 30 or more hours per week
- Are not an excluded individual
- Satisfy any other eligibility requirements

You are a participant if you are an eligible employee, have enrolled in the Medical FSA Plan, and have not terminated participation.

Eligible employees do not include:

- Leased employees
- Independent contractors
- Employees subject to a collective bargaining agreement (except as specifically provided in the collective bargaining agreement)
- Interns
- Employees classified as temporary
- Employees covered by written agreements stating they are not eligible to participate in this Plan.

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DEPENDENTS

- (a) To use the Medical FSA for reimbursement of medical expenses incurred by you for yourself or a family member who qualifies as your “Dependent”.
- (b) “Dependent” includes: (i) your spouse (to whom you are legally married); (ii) a person whom you can claim as a dependent on your federal income tax return; and (iii) a child whom you can claim as your health care tax dependent within the meaning of Code sections 105 or 106. This includes your son, daughter, stepson, stepdaughter or foster child who was under the age of 26 at the beginning of the calendar year.

ENROLLMENT AND PARTICIPATION

- (a) **Initial enrollment:** You must enroll within 30 days after becoming an Eligible Employee. Employees are eligible for this benefit the same as the employer's group medical plan at which time participation will begin. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement.
- (b) **Annual open enrollment:** If you do not enroll when you are first eligible, you must wait until the next Open Enrollment Period for another chance to participate (unless you experience an “Election Change Event” and make a “Qualifying Election Change,” as discussed later in this *Summary*). Federal tax law prohibits any other mid-year enrollment. The Open Enrollment Period for each Plan Year will be determined by the Plan Administrator.
- (c) **Enrollment procedure:** The Plan Administrator will provide enrollment instructions. You must complete your enrollment within the time specified by the Plan Administrator.
- (d) **Medical FSA election:** You must indicate the amount you want to contribute, if any, to a Medical FSA when you enroll.
- (e) **Mid-Year Enrollment:** You must enroll within 30 days after becoming an Eligible Employee. Employees are eligible for this benefit the same as the employer's group medical plan, at which time participation will begin. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement.

ELECTION CHANGES DURING THE PLAN YEAR

- (a) **Qualifying election changes:** Your election for any Plan Year cannot be changed during the Plan Year unless you experience an Election Change Event and make an election change that is on account of and consistent with the event (called a “Qualifying Election Change”). For complete details, request a copy of the Plan Document from the Plan Administrator or contact the Claims Administrator for assistance.

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(b) **Examples:**

1. If you get married, add a child to your family through birth or adoption or have a child who gains dependent status, you can increase your Medical FSA election.
2. If you divorce, a child no longer qualifies as your dependent, or your dependent dies, you can decrease your Medical FSA election.
3. If your spouse or a dependent start or ends a job or increases or decreases his or her work hours and gain or lose eligibility for employer-sponsored health insurance or health flexible spending account coverage as a result, you can make a corresponding increase or decrease your Medical FSA coverage through this Plan.
4. If a court order requires you or another person to provide health coverage for an eligible child, a corresponding change can be made in your Medical FSA contributions.
5. If you, your spouse or your dependent gains or loses Medicare or Medicaid coverage, a corresponding change can be made in the contributions to your Medical FSA.
6. You may change your Medical FSA election when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan Rules.

(c) **You cannot elect an amount less than the amount already reimbursed:** An election change will not be consistent with an Election Change Event if the new amount elected is less than the amount already reimbursed from the Medical FSA for the Plan Year.

(d) **Time limit for making election change:** To change your election, you must request an election change no later than 30 days after the Election Change Event (even if you are on leave at the time). You cannot change your election more than 30 days after an Election Change Event.

(e) **Election change process:** The Plan Administrator will provide instructions for requesting an election change. The Plan Administrator will determine whether an election change is permitted.

PARTICIPATION DURING A LEAVE OF ABSENCE

General Rules: Coverage will continue under this Plan during a leave of absence in accordance with the Company's leave policies and the terms and conditions of the Plan. If there is a conflict between the information provided in this section and the Company's leave policies, the Company's leave policies will control. The Company must approve your leave.

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You will be required to make your premium/contribution payments (“payments”) for coverage to continue. If you do not make the required payment when due, the Company may retroactively terminate your coverage to the last day for which you have paid. Expenses incurred during the period for which your coverage is retroactively terminated will not be covered. The Company can recover any payments owed. Upon return to work, the payments owed will be taken from your pay.

Contact the Plan Administrator for coverage payment options.

- (a) **Paid leave of absence:** Your Medical FSA coverage and your contributions for the coverage will automatically continue during a leave of absence as long as you continue to receive pay.
- (b) **Unpaid leave of absence:** Your right to continue Medical FSA coverage during unpaid leave depends on the type of leave. If you do not elect to continue your Medical FSA coverage at the beginning of leave, you will not be able to submit medical expenses you incur during the leave for reimbursement. Rules regarding specific types of unpaid leave are as follows.
 - 1. **FMLA Leave:** If you take FMLA leave, you may choose to continue or discontinue your Medical FSA coverage. You must notify the Company’s Human Resources Department of your decision.
 - i. If your Medical FSA coverage terminated, it will be reinstated on return from leave. You may choose to either reinstate the per pay-period contributions you had in place prior to leave (your contribution election for the Plan Year is reduced by the contributions you missed during your leave); or increase your per pay-period contributions for the rest of the Plan Year to make up the contributions you missed during your leave (your contribution election for the Plan Year remains the same).
 - ii. Even if you choose to increase your per pay-period contributions to make up the contributions you missed during the leave, you will still not be able to submit expenses you incurred during the leave for reimbursement. (Medical expenses you incur during the leave will be eligible for reimbursement only if you elected to continue your Medical FSA in advance of your leave.)
 - 2. **Military Leave:** If you go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), you may continue your group health plan and Medical FSA coverage for up to 24 months during the military leave to the extent required by USERRA. You must pay for the coverage. You may reinstate your coverage on return from leave to the extent required by USERRA. Contact the Company’s Human Resources Department for more information.

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3. **Other Types of Leave:** Contact the Plan Administrator for details. If your Medical FSA coverage terminates as a result of your leave, you may elect to continue your coverage through COBRA. Medical FSA COBRA rights are explained in the *Notice* section of this *Summary*. If you do not elect to continue your coverage through COBRA, you will not be eligible to recommence participation until the next Open Enrollment Period or you experience an Election Change Event.
- (c) **Open enrollment during your leave:** If the Open Enrollment Period for the next Plan Year occurs during your leave and your participation in the Plan continues, you will be able to make elections for Plan benefits for the new Plan Year in the same manner as active employees. If you do not elect Medical FSA benefits, you will not be eligible to participate in the Medical FSA in the new Plan Year, unless you experience an Election Change Event.
- (d) **Making election changes on return from leave:** Election changes other than as noted in this section will not be permitted on return from leave unless you experience another Election Change Event.

OBTAINING REIMBURSEMENTS

- (a) **Amount available for reimbursement:** Regardless of the amount you have contributed to the Medical FSA, the entire amount of your contribution election for the Plan Year (your Annual Contribution Election) less any prior reimbursements will be available to you at all times during the Plan Year. You will be reimbursed the entire amount of your claim, if it is less than your Annual Contribution Election.
- (b) **Expense must be eligible for reimbursement under this plan:** The expense must qualify as medical care within the meaning of the Plan for reimbursement from the Medical FSA.
- (c) **Expense must have been incurred during your period of coverage for plan year:** You may only use your Medical FSA to pay for Medical Expenses that you incurred during the Plan Year. Expenses incurred during one Plan Year cannot be reimbursed from contributions in another Plan Year. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter. The only exception is that expenses may be treated as incurred for orthodontia services before the services are provided if the orthodontist (following his or her normal practice) requires you to make advance payments to receive the services (*e.g.*, requires you to pay a lump sum for services to be provided that year and the next).
- (d) **Expense cannot be reimbursed out of other accounts:** Amounts contributed to the Medical FSA cannot be used to reimburse expenses from the Dependent Care FSA and vice versa.
- (e) **Claim submission requirements must be satisfied.** You may submit a completed claim form and independent third-party documentation of the claim to the Administrator. If your Company implements an electronic payment card program (debit card, credit card)

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to pay expenses from the Medical FSA Plan, some expenses may be validated at the time the expense is incurred (like copays for medical care). For other expenses, the card payment is only conditional. You will still have to submit supporting documents. You will receive more information from the Company about what you must do to obtain reimbursement if such a system is implemented.

1. *Claims must be submitted during the Plan's Claims Submission Period.*
HealthEquity must receive all claims for reimbursement in our office no later than 90 days after the plan year end date to be reimbursed.
For employees that have terminated during the plan year claims must be received in our office 30 days from the termination date.
 2. *Documentation must be provided.* To receive reimbursement for an Eligible Expense, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill or receipt) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is incomplete, the claim may be denied and payment delayed.
 3. *Claims cannot be reimbursed by Health Insurance.* You cannot submit claims for reimbursement if you have already been reimbursed by health insurance or if you intend to request reimbursement.
- (f) **Method of reimbursement:** To the extent the Claims Administrator determines that a claim is properly payable under the Plan; you will be reimbursed for the expense either through a check or via direct deposit, if you have selected that option. Reimbursements will be issued as scheduled by the Claims Administrator.
- (g) **Recovery of improper reimbursements:** You will be required to repay the Plan for reimbursements determined by the Claims Administrator to be ineligible for reimbursement under the Plan or otherwise improper. The Claims Administrator may use one or more of the following recovery methods: (i) you repay the amount to your Medical FSA or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount from future reimbursement payments to you for Eligible Medical Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement will be treated as a business debt and the amount reimbursed will be included in your W-2 income.

CLAIMS AND APPEAL PROCEDURE

- (a) **Initial determination on claim for reimbursement**
1. *Time Period.* Within 30 days after receipt of a claim, the Claims Administrator will make its decision on the claim. The 30-day period for the initial review

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determination by the Plan Administrator may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Plan; and (ii) the Administrator provides notice of the extension to you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Plan expects to render its decision. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.

2. *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notification of the denial to you which will include the specific reason for the denial, a reference to the Plan provision on which the denial is based, a description of additional information or documents necessary in order for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure.

(b) **Appeal rights and procedures.**

1. *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Plan Administrator. You must send a written request for an appeal review to the Plan Administrator within 180 days of your receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.
2. *Right to Review Documents/Submit Comments.* You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Plan administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.
3. *Person Conducting Review.* The review will be conducted by a person who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination.
4. *Notice of Continued Denial.* If the denial is upheld in whole or part, the Claims Administrator will send notification of the denial to you. You will be notified of the Claims Administrator's decision on appeal in writing within 60 days after

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receipt of your appeal. The notice will include the Claims Administrator's reason for its decision.

FORFEITURE OF ACCOUNT BALANCE

Forfeiture: According to federal tax law, amounts remaining in your Medical FSA after the end of the Claims Submission Period following payment of Eligible Expenses incurred during the Plan Year must be forfeited. Such forfeited amounts will be used by the Plan Administrator, in its discretion, to pay the cost of benefits under the Plan, for administrative costs of the Plan, or to provide additional benefits to participants. Planning carefully on the amount to contribute to the spending accounts should help you to avoid forfeitures.

CARRYOVER OPTION

Your employer has offered a carryover of the Medical FSA; the amount that may be carried over to the following plan year is equal to the lesser of:

1. any unused amount from the immediately preceding plan year, or;
2. \$660. The carryover dollar limit may increase for cost-of-living adjustments.
3. \$0 minimum from the immediate preceding plan year.

The specific Carryover amount is generally determined at the end of the run out period following such Plan Year ("Carryover"). The Carryover amount does not affect the maximum amount of salary reduction contributions that the participant is permitted to make under §125(i) of the Code.

If you incur an eligible expense during a Plan Year ("Current Year Expense") but before the end of the prior Plan Year's run out period, the plan administrator may, at its discretion, apply up to \$500 of the amount unused at the end of the prior Plan Year (if any) towards the Current Year Expense. NOTE: This will reduce the amount that is available to reimburse expenses incurred during the prior Plan Year ("Prior Year Expenses") submitted during the prior Plan Year's run out period and it will reduce the Carryover Maximum by the same amount.

If you are otherwise eligible for the Medical FSA for a Plan Year but you do not make an election to participate, you may still use any Carryover from the Prior Plan Year for Current Year Expenses and Prior Year Expenses (in accordance with terms of the Plan and the ordering rules described above).

Under IRS rules, if you have unused Medical FSA amounts on the last day of a Plan Year in a general purpose Medical FSA (i.e., anything other than a \$0 balance), you (and your spouse, if you are married) cannot contribute to an HSA during the following plan year. For this purpose, whether you have unused Medical FSA amounts is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not the claims have been submitted). Therefore, if you chose to establish an HSA in the following Plan year, your Carryover amounts will be directed to a limited purpose Medical FSA (if offered).

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You must be a participant in the Medical FSA as of the last day of the Plan Year to benefit from the Carryover. Termination of employment and cessation of eligibility will generally result in a loss of Carryover eligibility unless a COBRA election is made.

TERMINATION OF PARTICIPATION DUE TO TERMINATION OF EMPLOYMENT

1. **When participation ends:** If your employment with the Company terminates, your participation in the Plan will end as of the date of your termination of employment.
2. **Medical expenses incurred after termination:** Medical expenses incurred after the date of your termination from employment will not be eligible for reimbursement unless you elect to continue your participation in the Medical FSA. Please refer to the COBRA continuation information in the “Notice” section below.
3. **Amounts remaining after termination:** Any amounts remaining in an account after the end of the Claims Submission Period for the Plan Year in which the termination occurred will be forfeited.
4. **Re-employment by a Participating Employer:** If you terminate employment and are re-employed by a participating employer, you may participate in the Plan. Whether you are required to resume your elections in place prior to your termination or may make new elections depends on the length of time between your termination and reemployment and whether you are reemployed in the same Plan Year or a new Plan Year.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class within 30 days and within the same Plan Year will be required to resume participation in the Plan and the participant’s prior benefit elections will be reinstated.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class after 30 days or more and within the same Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class in a new Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

OTHER REASONS FOR TERMINATION OF PARTICIPATION

- (a) Your participation in this Plan can also end if:
 1. you no longer qualify as an Eligible Employee;

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2. your Employer stops participating in this Plan;
 3. you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan;
 4. the Company terminates the Plan; or
 5. if the certifications you made to participate are no longer accurate
- (b) The rules discussed above for termination of participation as a result of termination of employment also apply if termination of participation occurs for other reasons.

NOTICES

- (a) **COBRA Continuation of Medical FSA Coverage:** You, your spouse or any of your dependents who lose coverage under the Medical FSA as a result of a "qualifying event" are "qualified beneficiaries" and will be eligible to continue Medical FSA coverage for the remainder of the current Plan Year as indicated in this section.
1. *Medical FSA Positive Balance Requirement.* To be eligible for COBRA: (i) there must be a positive balance in your Medical FSA as of the date your coverage would otherwise terminate because of a qualifying event; and (ii) the COBRA Premiums you are required to pay for the remainder of the Plan Year must exceed available reimbursements.
 2. *Qualifying Events.* For employees, the qualifying events are: (i) termination of employment for any reason other than gross misconduct; and (ii) a reduction in hours. For a spouse or dependent, the qualifying events may include: (i) the employee's termination of employment for any reason other than gross misconduct; (ii) the employee's loss of eligibility for coverage due to a reduction in scheduled work hours; (iii) the employee's death; (iv) the employee's divorce or legal separation; (v) a dependent child's ceasing to qualify as an eligible dependent under the Medical FSA; and (vi) the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).
 3. *Maximum COBRA Coverage Period.* COBRA continuation coverage is a temporary continuation of Medical FSA coverage. For each qualified beneficiary who elects COBRA continuation coverage, the COBRA coverage will begin on the date of the qualifying event. The maximum COBRA coverage period is through the end of the Plan Year in which the qualifying event occurred. The continuation coverage period is a maximum period that will be reduced as described below.
 4. *You must provide notice to the Plan Administrator of certain events.* The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan

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Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or the employee's death, the employer will notify the Plan Administrator of the Qualifying Event. Qualified beneficiaries must notify the Plan Administrator of the employee's divorce, legal separation or child's ceasing to qualify as a dependent under the Medical FSA within 60 days of the date of the qualifying event. If the Plan Administrator is not given the notice within 60 days, the right to continue coverage will be lost.

5. The notice must be in writing, must contain the information described below, and must be mailed by first class mail, postage prepaid and addressed to the Plan Administrator at the address indicated in the **Plan Specifications** section of this summary.
6. The notice must contain the following information: (i) the name, address and Social Security Number of the employee; (ii) the name, address and Social Security Number of each qualified beneficiary (e.g., employee, spouse, dependent child); (iii) a description of the qualifying event; (iv) the date of the qualifying event; and (v) a list of the Benefit Options under which the affected qualified beneficiaries are covered.
7. *Type of Coverage available for Continuation.* A qualified beneficiary may elect to continue the Medical FSA coverage in effect immediately before the qualifying event.
8. *Who may elect COBRA Coverage?* An employee can make the election for himself or herself, his or her spouse, or any of his or her dependent children. If the employee does not make the election, his or her spouse can make the election for himself or herself and any dependent children. Finally, if neither the employee nor spouse makes the election for a dependent child, the dependent may make the election for him or herself. (A child who is born to, or placed for adoption with, the employee while the employee is continuing coverage under COBRA and who becomes covered by the Medical FSA will have independent COBRA election rights as if he or she were covered at the time of the qualifying event.)
9. *COBRA Election Period.* After a qualifying event or receiving notice of a qualifying event (if notice is required), the Plan Administrator will send qualified beneficiaries a notice regarding COBRA election rights. Qualified beneficiaries will have 60 days from the date of such notice (or from the date coverage would otherwise terminate because of the qualifying event, if the coverage would stop after the notice is sent) in which to file a written election to continue coverage. If a qualified beneficiary does not file the election within the 60-day period, he or she will lose the right to continue Medical FSA coverage. The election must be filed with the Plan Administrator at the address specified in the election form.

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10. *COBRA Contributions.* Contributions for the continuation coverage will be on an after-tax basis unless your Compensation continues and the Plan Administrator permits pre-tax contributions for continuation coverage. A qualified beneficiary must pay the full contribution, plus a 2% administration fee, for any coverage he or she continues. He or she must make the first contribution payment, covering the period between the date coverage would otherwise stop and the end of the month preceding the date of the payment, within 45 days after the date the election to continue coverage was filed. Subsequent contributions are due on the first day of each month for which a qualified beneficiary continues coverage, and coverage will end if he or she fails to pay the contribution for any month within 30 days after the due date.
 11. *No COBRA Coverage Pending Election or Payment.* A qualified beneficiary will not have COBRA coverage until he or she has elected the coverage and made the required contribution payment. No claims for health care incurred while coverage is not in effect will be eligible for reimbursement. Once a qualified beneficiary makes the election and pays the contribution, coverage will be reinstated retroactively to the date he or she lost the coverage.
 12. *Termination of COBRA Coverage.* The continuation coverage will terminate when the first of the following events occurs: (i) the end of the current Plan Year; (ii) the qualified beneficiary fails to pay the initial contribution within 45 days after your election, in which case he or she will be treated as not having elected to continue Medical FSA coverage; (iii) the qualified beneficiary fails to pay any other contribution within 30 days after it is due, in which case coverage will end as of the end of the last day of the month for which he or she made a timely contribution payment; (iv) after electing continuation coverage, the qualified beneficiary becomes entitled to any other group health plan that does not limit or exclude coverage because of a preexisting condition (coverage already in place at the time of the continuation coverage election will not cause termination of continuation coverage); and (v) the employer ceases to provide Medical FSA account benefits to any of its employees.
 13. *Keep the Plan informed of Address Changes.* To protect Medical FSA COBRA continuation rights, qualified beneficiaries should keep the Plan Administrator informed of any address changes.
 14. *Keep Copies of Notices.* Qualified beneficiaries should also keep copies for their records of any notices sent to the Plan Administrator.
 15. *Plan Administrator Contact Information.* The address and telephone number for the Plan Administrator is listed in the **Plan Specifications** section of this summary.
- (b) **HIPAA Privacy Rule Notice of Privacy Practices:** The Medical FSA component of the Plan is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the Plan's

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Notice of Privacy Practices (which summarizes the Plan's Privacy Rule obligations, your Privacy Rule rights, and how the Plan may use or disclose health information protected by the Privacy Rule) from the Plan Administrator.

- (c) **Statement of ERISA Rights of Plan Participants:** 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:

1. *Receive Information about your Plan and Benefits.*
 - i. Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan 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.
 - ii. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 series) and the latest updated summary plan description. This *Summary*, along with the Plan Document for the HRA, comprise the Plan Document for this benefit. The Plan Administrator may make a reasonable charge for the copies.
 - iii. 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.
2. *Continue Group Health Plan Coverage.* Continue health care coverage 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 for your HRA COBRA continuation rights.
3. *Prudent Actions by Plan Fiduciaries.* In addition to creating rights for Plan Participants ERISA imposes duties upon the people who are responsible for the operation of this 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 benefit provided under this Plan or exercising your rights under ERISA.
4. *Enforce your Rights.* 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.

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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 medical child support order, you may file suit in Federal court. 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.

5. *Assistance with your Questions.* If you have any questions about this 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 (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution 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.
- (d) **Company's right to terminate or amend the Plan:** The Company reserves the right to amend or terminate the Plan at any time and without notice.
- (e) **No guarantee of employment:** Participation in this Plan is not a guarantee of employment.
- (f) **Plan Administrator's discretion:** The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

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Plan number 501
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Claims Administrator:

HealthEquity
P.O BOX 14374
Lexington KY, 40512

Plan Year:

September 1 through August 31

The Waterfront Beach Resort

Flexible Spending Plan

Dependent Care FSA Summary

Dependent Care FSA Summary

INTRODUCTION

The Waterfront Beach Resort's Flexible Benefit Plan (the "Plan") permits Eligible Employees to choose to pay for certain benefits on a pre-tax basis.

This *Summary* describes the Dependent Care Flexible Spending Account ("Dependent Care FSA") Benefit Option under the Plan. Terms may be defined in this *Summary* and in the *Plan Document*.

Through the Dependent Care FSA, you can pay Dependent Care Expenses on a pre-tax basis. This will generally result in a tax savings and increase your spendable income.

The tax benefit you experience will depend on the benefits you elect, as well as other factors that affect the amount of taxes you pay. Although participating in the Plan can provide significant tax advantages, there may be tax disadvantages to participating in the Plan based on your particular situation. You may wish to consult with your tax advisor.

DETAILS OF THE DEPENDENT CARE FSA BENEFIT

- (a) **Dependent care Expenses Eligible for reimbursement:** You can use your Dependent Care FSA to pay for Dependent Care Expenses. Dependent Care Expenses must be work-related to be eligible for reimbursement. Details are provided below. **The maximum annual contribution for this benefit is up to the IRS maximum each plan year. Note that salary reduction amounts from the last paycheck of the Plan Year may be used to pay for the first month of benefits elected for the next Plan Year.**

1. "Dependent Care Expense" means:
 - i. an amount that you incur for the Care of a Qualifying Individual and Household Services incidental to that care
 - ii. to enable you, and if you are married, your spouse to be "gainfully employed" or to actively search for "gainful employment" (*i.e.*, the dependent care must be necessary for you to work or to find work)
2. A Dependent Care Expense is "incurred" on the date on which the services are provided, regardless of the date on which payment for such services is due or made.
3. "Qualifying Individual" is defined below.

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4. “Care of a Qualifying Individual” means services, the primary purpose of which is to provide for the Qualifying Individual’s well-being and protection. It does not include the provision of food, clothing or education unless such benefits are incidental to such primary purpose and does not include the provision of education to an individual in kindergarten or any higher grade.
 5. “Household Services” are services performed in and around your home that are ordinary and usual services necessary to maintain your household and are attributable, at least in part, to the Care of the Qualifying Individual.
 6. “Gainfully employed” or “gainful employment” means a job. Your spouse will be deemed to be gainfully employed during any month in which he or she is either a full-time student at an educational institution or is a Qualifying Individual (*i.e.*, physically or mentally incapable of caring for himself or herself).
- (b) **You must request reimbursement:** To receive reimbursement for Dependent Care Expenses, you must submit a completed claim form (which includes your promise that the expenses have not been reimbursed from any other source and that you will not seek reimbursement for the expenses from any other source) and independent third-party documentation of the expense.
- (c) **Maximum benefits:** Federal law limits the amount that can be reimbursed from your Dependent Care FSA if you are married but file a separate federal income tax return and if you are single or married filing a joint federal income tax return. Moreover, benefits can never be more than your “earned income” for the year. Your earned income is your adjusted gross income or, if less, the adjusted gross income of your spouse if you are married. If your spouse is unemployed because he or she is incapable of self-care or is a full-time student, your spouse will be deemed to have an earned income of a certain amount per month depending upon whether there is one Qualifying Individual or two or more Qualifying Individuals. IRS Publication 503, which you may obtain from the IRS’s web site at <http://www.irs.gov> describes the deemed earned income limitation.
- (d) **Dependent Care tax credit:** The federal tax law allows you to take a tax credit on your federal income tax return for qualified dependent care expenses in an amount up to \$3,000 for one dependent and up to \$6,000 for two or more dependents. (Your potential tax credit is a percentage of these amounts that depends on your adjusted gross income). The difference between the Dependent Care FSA and the tax credit is that the Dependent Care FSA provides a reduction in your taxable income, while the tax credit offers a direct reduction on the amount of tax you pay. You cannot use the Dependent Care FSA and the tax credit for the same expenses. In addition, use of the Dependent Care FSA will reduce dollar for dollar or eliminate your tax credit. You will need to determine which of these methods is best for you, because each person’s tax situation is unique, your own tax advisor should be consulted to help you determine which approach is best for you.
- (e) **Reimbursements are reported on form W-2:** The reimbursements you receive for

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Dependent Care Expenses will be reported to the IRS on your W-2 Form for the year. These amounts should not generally be taxable unless: (i) your reimbursements exceed your earnings for the year or, if you are married on the last day of the year, your spouse's earnings for the year; or (ii) you do not report the taxpayer identification number of your dependent care service provider when you file your federal income tax return.

- (f) **Dependent Care provider information on tax return:** You will be required to list on your annual tax return the names and taxpayer identification numbers of any persons who provided you with dependent/day care services during the calendar year for which you have claimed a tax-free reimbursement.
- (g) **Expenses cannot be reimbursed from any other source, including tax credits or tax deductions:** Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud and you personally will be responsible for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.

ELIGIBLE EMPLOYEES

Only eligible employees may participate. You are eligible if you are:

- Employed by the company or a participating employer
- Regularly scheduled to work 30 or more hours per week
- Are not an excluded individual
- Satisfy any other eligibility requirements

You are a participant if you are an eligible employee, have enrolled in the Dependent Care FSA Plan, and have not terminated participation.

Eligible employees do not include:

- Leased employees
- Independent contractors
- Employees subject to a collective bargaining agreement (except as specifically provided in the collective bargaining agreement)
- Interns
- Employees classified as temporary

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- Employees covered by written agreements stating they are not eligible to participate in this Plan.

DEPENDENTS

- (a) You may only use the Dependent Care FSA to be reimbursed for expenses of someone who qualifies as your Dependent.
- (b) For the Dependent Care FSA, "Dependent" means someone who meets the requirements of a "Qualifying Individual." If a Dependent ceases to meet these requirements during a Plan Year (e.g., a dependent child turns 13), Eligible Dependent Care Expenses incurred before the Dependent ceased to meet the requirements may still be reimbursed.
- (c) A Qualifying Individual means an individual who is your Qualifying Child, Qualifying Spouse or Qualifying Relative, as defined below

If you and your child's other parent do not live together, only the parent with primary physical custody (parent with whom the child resides for more than six months out of the year) can be reimbursed for Dependent Care Expenses for the child and then only for the days in which the child resides with him or her. The other parent cannot seek reimbursement of Dependent Care Expenses even for the days during which the child resides with him or her.

1. *A Qualifying Child.* This means an individual who:
 - i. has one of the following relationships to you: son, daughter, stepdaughter, stepson, brother, sister, stepbrother, stepsister, foster child, or child for whom the you have legal guardianship (or a descendent of any of these individuals);
 - ii. is under the age of 13;
 - iii. lives with you for more than one half the year; and
 - iv. does not provide more than one half of his or her own support.
2. *A Qualifying Spouse.* This means your spouse who:
 - i. lives with you for more than half of the year; and
 - ii. is physically or mentally incapable of self-care.
3. *A Qualifying Relative.* This means an individual:
 - i. who has a "Qualifying Child" relationship to you (as specified in subsection (c)(1)(i) above) or who is your father, mother, stepfather, stepmother,

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niece, nephew, aunt, uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law, or who lives with you and is a member of your household;

- ii. who is not your Qualifying Child or the Qualifying Child of any other person;
- iii. for whom over one half of whose support for the year is provided by you;
- iv. who lives with you more than half of the year; and
- v. who is physically or mentally incapable of self-care.

ENROLLMENT AND PARTICIPATION

- (a) **Initial Enrollment:** You must enroll within 30 days of becoming an Eligible Employee. An eligible employee may participate in the Plan following 60 days of employment. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement.
- (b) **Annual Open Enrollment:** If you do not enroll when you are first eligible, you must wait until the next Open Enrollment Period for another chance to participate (unless you experience an “Election Change Event” and make a “Qualifying Election Change,” as discussed later in this *Summary*). Federal tax law prohibits any other mid-year enrollment. The Open Enrollment Period for each Plan Year will be determined by the Plan Administrator.
- (c) **Enrollment procedure:** The Plan Administrator will provide enrollment instructions. You must complete your enrollment within the time specified by the Plan Administrator.
- (d) **Dependent Care FSA election:** You must indicate the amount you want to contribute, if any, to a Dependent Care FSA when you enroll.
- (e) **Mid-Year Enrollment:** You must enroll within 30 days after becoming an Eligible Employee. Employees are eligible for this benefit following 60 days of employment, at which time participation will begin. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement.

ELECTION CHANGES DURING THE PLAN YEAR

- (a) **Qualifying Election Changes:** Your election for any Plan Year cannot be changed during the Plan Year unless you experience an Election Change Event and make an election change that is on account of and consistent with the event (called a “Qualifying Election Change”). For complete details, request a copy of the Plan Document from the Plan Administrator or contact the Claims Administrator for assistance.
- (b) **Examples.**

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1. If you add a child to your family (through birth or adoption), you can increase your Dependent Care FSA election.
 2. If a child or other Dependent is no longer a Qualifying Individual (for example, your child turns 13), you may decrease or terminate your Dependent Care FSA election.
 3. If you divorce and your child no longer lives with you, you may decrease or terminate your Dependent Care FSA election.
 4. If your cost for dependent care changes, you may make a corresponding change to your Dependent Care FSA election (unless your Dependent Care provider is a relative).
 5. If your need for dependent care changes due to a job change or a change in work hours, you may make a corresponding change to your Dependent Care FSA election.
- (c) **You cannot elect an amount less than the amount already reimbursed:** An election change will not be consistent with an Election Change Event if the new amount elected is less than the amount already reimbursed from the Dependent Care FSA for the Plan Year.
- (d) **Time limit for making election change:** To change your election, you must request an election change not later than 30 days after the Election Change Event (even if you are on leave at the time). You cannot change your election more than 30 days after an Election Change Event.
- (e) **Election change process:** The Plan Administrator will provide instructions for requesting an election change. The Plan Administrator will determine whether an election change is permitted.

PARTICIPATION DURING A LEAVE OF ABSENCE

General rules. Coverage will continue under this Plan during a leave of absence in accordance with the Company's leave policies and the terms and conditions of the Plan. If there is a conflict between the information provided in this section and the Company's leave policies, the Company's leave policies will control. Your leave must be approved by the Company.

You will be required to make your premium/contribution payments ("payment" or "payments") for coverage to continue. If you do not make the required payment when due, the Company may retroactively terminate your coverage to the last day for which you have paid. Expenses incurred during the period for which your coverage is retroactively terminated will not be covered. The Company can recover any payments owed. Upon return to work, any payments owed will be taken from your pay. Contact the Plan Administrator for coverage payment options.

Additional Rules for Dependent Care FSAs

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- (a) **Paid Leave of Absence:** Your Dependent Care FSA contributions will automatically continue as long as you continue to receive pay. Although you will continue to contribute to your Dependent Care FSA during a paid leave, dependent care expenses you incur during the leave will not be eligible for reimbursement due to tax rules. Do not submit claims for reimbursement for dependent care expenses incurred during your leave.
- (b) **Unpaid Leave of Absence:** Your Dependent Care FSA contributions will terminate during an unpaid leave. Dependent care expenses you incur during an unpaid leave will not be eligible for reimbursement. You may reinstate your Dependent Care FSA contributions on return from leave.
- (c) **Open Enrollment during your Leave:** If the open enrollment period for the next Plan Year occurs during your leave and your participation in the Plan continues, you will be able to make elections for Plan benefits for the new Plan Year in the same manner as active employees. If you do not elect Dependent Care FSA benefits, you will not be eligible to participate in these benefits in the new Plan Year, unless you experience an Election Change Event and make an election change within 30 days of that event.
- (d) **Making Election Changes on return from Leave:** Election changes other than as noted in this section will not be permitted on return from leave unless you experience another Election Change Event and make the election change within 30 days of the event.

PART-TIME EMPLOYMENT AND ABSENCES FROM WORK FOR MINOR ILLNESS OR VACATION

- (a) **Part-Time Employment:** Only Dependent Care Expenses incurred on the days during the week that both you and your spouse are working are eligible for reimbursement. If you and/or your spouse work part-time but are required to pay for dependent care on a weekly or monthly basis for both days worked and not worked (part-time daycare is not available), the entire cost will be eligible for reimbursement.
- (b) **Temporary-Absences due to minor illness or vacation:** Only Dependent Care Expenses incurred on the days during the week that both you and your spouse are working are eligible for reimbursement. Dependent Care Expenses incurred while you and/or your spouse are absent from work for a few days due to a minor illness or vacation, however, are still eligible for reimbursement if you are required to pay for dependent care on a weekly or monthly basis for both days worked and not worked. An absence of no more than two consecutive weeks is considered a temporary absence.

OBTAINING REIMBURSEMENTS

- (a) **Amount available for reimbursement:** The amount available for reimbursement during the Plan Year will be limited to the balance in your Dependent Care FSA (your payroll contributions, less any reimbursements already made from the Account for that Plan Year).

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- (b) **Expense must be eligible for reimbursement under this Plan:** The expense must qualify as a Dependent Care Expense within the meaning of the Plan for reimbursement from the Dependent Care FSA.
- (c) **Expense must have been incurred during your period of coverage for Plan Year:** You may only use your Dependent Care FSA to pay for Dependent Care Expenses that you incurred during the Plan Year. Expenses incurred during one Plan Year cannot be reimbursed from contributions made during another Plan Year. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter.
- (d) **Expense cannot be reimbursed out of other accounts:** Amounts contributed to the Dependent Care FSA cannot be used to reimburse expenses from the Medical FSA and vice versa.
- (e) **Claim submission requirements must be satisfied.** You may submit a completed claim form and independent third-party documentation of the claim to the Administrator. You may also submit your claim Online.
 - 1. *Claims must be submitted during the Plan's Claims Submission Period.* **HealthEquity must receive all claims for reimbursement in our office no later than 90 days after the plan year end date to be reimbursed.**

For employees that have terminated during the plan year, claims must be received 30 days from the termination date.
 - 2. *Documentation must be provided.* To receive reimbursement for an Eligible Expense, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill or receipt) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is incomplete, the claim may be denied and payment delayed.
- (f) **Method of reimbursement:** To the extent the Claims Administrator determines that a claim is properly payable under the Plan; you will be reimbursed for the expense, either through a check or via direct deposit, if you have selected that option. Reimbursements will be issued as scheduled by the Claims Administrator. Your claim for a Dependent Care Expense will be paid up to the amount you have contributed to your Dependent Care FSA as of the day the claim is processed. If the claim amounts exceed the amount in your account, you will be reimbursed up to the amount available in your account. A claim balance will be carried forward and will be paid when additional funds become available. You do not need to send in more than one claim for an Eligible Expense.
- (g) **Recovery of improper reimbursements:** You will be required to repay the Plan for reimbursements determined by the Claims Administrator to be ineligible for

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reimbursement under the Plan or otherwise improper. The Claims Administrator may use one or more of the following recovery methods: (i) you repay the amount to your Dependent Care FSA or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount from future reimbursement payments to you for Eligible Dependent Care Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement may be treated as a business debt and the amount reimbursed will be included in your W-2 income.

CLAIMS AND APPEAL PROCEDURE

(a) Initial determination on claim for reimbursement

1. *Time Period.* Within 30 days after receipt of a claim, the Claims Administrator will make its decision on the claim. The 30-day period for the initial review determination by the Claims Administrator may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Plan; and (ii) the Administrator provides notice of the extension to you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Plan expects to render its decision. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.
2. *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notification of the denial to you which will include the specific reason for the denial, a reference to the Plan provision on which the denial is based, a description of additional information or documents necessary in order for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure.

(b) Appeal Rights and Procedures.

1. *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Claims Administrator. You must send a written request for an appeal review to the Claims Administrator within 180 days of your receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.
2. *Right to Review Documents/Submit Comments.* You have the right to receive,

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upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Claims Administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.

3. *Person Conducting Review.* The review will be conducted by a person who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination.
4. *Notice of Continued Denial.* If the denial is upheld in whole or part, the Claims Administrator will send notification of the denial to you. You will be notified of the Claims Administrator's decision on appeal in writing within 60 days after receipt of your appeal, this includes both levels of appeals. The notice will include the Claims Administrator's reason for its decision.

FORFEITURE OF ACCOUNT BALANCE

Forfeiture: According to federal tax law, amounts remaining in your Dependent Care FSA after the end of the Claims Submission Period following payment of Eligible Expenses incurred during the Plan Year must be forfeited. Such forfeited amounts will be used by the Plan Administrator, in its discretion, to pay the cost of benefits under the Plan, for administrative costs of the Plan, or to provide additional benefits to participants. Planning carefully on the amount to contribute to the spending accounts should help you to avoid forfeitures.

TERMINATION OF PARTICIPATION DUE TO TERMINATION OF EMPLOYMENT

- (a) **When Participation ends:** If your employment with the Company terminates, your participation in the Plan will end as of the date of your termination of employment.
- (b) **Amounts remaining after Termination:** Any amounts remaining in an account after the end of the Claims Submission Period for the Plan Year in which the termination occurred will be forfeited.
- (c) **Re-employment by a Participating Employer:** If you terminate employment and are re-employed by a participating employer, you may participate in the Plan. Whether you are required to resume your elections in place prior to your termination or may make new elections depends on the length of time between your termination and reemployment and whether you are reemployed in the same Plan Year or a new Plan Year.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class within 30 days and within the same Plan Year will be required to resume participation in the Plan and the participant's prior benefit

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elections will be reinstated.

A Participant who terminates employment and is re-employed by a participating employer in an eligible employee class after 30 days or more and within the same Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

A Participant who terminates employment and is re-employed by a participating employer in an eligible employee class in a new Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

OTHER REASONS FOR TERMINATION OF PARTICIPATION

- (a) Your participation in this Plan can also end if:
 - 1. you no longer qualify as an Eligible Employee;
 - 2. your Employer stops participating in this Plan;
 - 3. you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan; or
 - 4. the Company terminates the Plan.
- (b) The rules discussed above for termination of participation as a result of termination of employment also apply if termination of participation occurs for other reasons.

NOTICES

- (a) **ERISA, HIPAA and COBRA do not apply:** The Dependent Care FSA is not an employee benefit plan within the meaning of ERISA and is not subject to ERISA, HIPAA or COBRA.
- (b) **Company's right to terminate or amend the Plan:** The Company reserves the right to amend or terminate the Plan at any time and without notice.
- (c) **No guarantee of employment:** Participation in this Plan is not a guarantee of employment.
- (d) **Plan Administrator's discretion:** The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

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