Liberty Mutual Employees’ Flexible Spending Accounts
Summary Plan Description

Effective January 1, 2017
Section H
FLEXIBLE SPENDING ACCOUNTS

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GENERAL PROVISIONS
FLEXIBLE SPENDING ACCOUNTS

Overview

Liberty Mutual Employees' Flexible Spending Accounts (the “Plan”) allow you to set aside money, on a before-tax basis, to pay for certain health care and dependent care expenses. Before-tax contributions are dollars you elect to have deducted from your pay before federal, state (if applicable), and Social Security taxes are deducted. This reduces your taxable income, which means you will pay fewer taxes. Also, reimbursements you receive from the accounts are generally tax-free.

Eligibility

Employees on the U.S. payroll who are regularly scheduled to work 20 or more hours per week are eligible to participate on their date of employment. Individuals classified as independent contractors or leased employees are not eligible to participate, even if they are later reclassified as common law employees for tax purposes. If you do not enroll within thirty (30) days of your date of eligibility, you must wait until the next annual Benefits Enrollment period. The only exceptions is if you have a “Qualified Status Change” (refer to “Changing Your Contributions” for details).

You may enroll in the Plan on the Your Total Rewards website. When you enroll, keep the following in mind:

- Your pay will be reduced each payday in equal installments throughout the year. If you become eligible mid-year, you may still elect to contribute up to the maximum annual amount. Your contribution will be deducted from the paychecks that remain in that plan year. Only expenses incurred after your enrollment date are considered eligible.

Note: The IRS does not allow Consumer Directed Health Plan (CDHP) participants with a Health Savings Account (HSA) to also have a general purpose Health Care Flexible Spending Account (FSA), nor can your spouse have a general purpose Health Care FSA.

Health Care Flexible Spending Account

A Health Care Flexible Spending Account (FSA) can be used to pay for most health care expenses that are not covered or reimbursed by the Medical, Dental, or Vision Care Plans. To qualify for purposes of submitting a claim under an FSA, an individual must either be your spouse, or meet the definition of “dependent,” as defined under Internal Revenue Code (“Code”) Section 152, as modified by Section 105(b). Note: If you participate in the Consumer Directed Health Plan (CDHP) option, you may not enroll in the Health Care Flexible Spending Account.

You can set aside between $100 and $2,550 in one calendar year. Eligible expenses include:

- amounts you pay to satisfy health plan deductibles;
• any coinsurance you pay after your deductible or coinsurance and co-payments to your provider; and

• many health care costs that may not be covered by the Medical, Dental, or Vision Care Plans, such as:
  - hearing care, including hearing aids; and
  - other medical expenses that are deductible for federal income tax purposes.

A more detailed list is shown under the heading “Eligible Health Care Expenses.”

You may carry over to the following calendar year a minimum of $50, up to $500 of the amount you have set aside that remains unused at the end of the year. You may use the carried over amount to pay for or to be reimbursed for Eligible Health Care Expenses incurred in the following year. The carry over amount will not reduce the amount that you may otherwise set aside for that calendar year. For instance, if, on December 31, 2016, you have not used $500 of the amount you set aside in the Health Care Flexible Spending Account, you may use that amount to cover Eligible Health Care Expenses incurred in 2017 and, for 2017, still set aside $2550 in your Health Care Flexible Spending Account.

**Dependent Care Flexible Spending Account**

Dependent Care Flexible Spending Accounts (FSA) cover many expenses related to the care of a qualifying individual or individuals so that both you and your spouse can work (see specific list below) and the primary purpose of the care must be to assure the well-being and protection of the qualifying individual. Your spouse is also generally considered to be “at work” in any month in which he or she is a full-time student or incapable of self-care.

For the Dependent Care FSA, you may set aside as little as $100. The maximum annual amount you can contribute is the lesser of:

- $5,000 ($2,500 if married, filing separate returns); or
- your spouse's earned income. (If your spouse is a full-time student or incapable of self-care in any month, his or her earned income is assumed to be $250 for that month if there is one qualifying individual in your home, or $500 if there are two or more qualifying individuals in your home. A spouse who cannot care for himself or herself is counted as a qualifying individual.)

If you are considered a highly compensated employee (HCE) as determined under the Code, federal law may require your Dependent Care FSA contribution election to be limited based on the results of non-discrimination testing. If you are affected, you will be notified prior to your election of any limitation to your contributions. For 2017, the limit for highly compensated employees is $3,400.

Dependent care expenses are generally eligible for reimbursement if they meet the following conditions:

- the annual amount submitted for reimbursement does not exceed the earned income of the lower-paid spouse; and
- the expenses are employment-related expenses for the care of your dependent who is a qualifying individual.

**Qualifying Individual**

A qualifying individual under Code Section 21 of the Internal Revenue Code (“Code”) means an individual who:

- can be claimed by the employee as a dependent (as defined in Code Section 152(a)(1));
• is under age 13; and
• lives with the taxpayer for more than six months of the taxable year.

In addition, a qualifying individual includes:

• the employee’s spouse, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal residence as the employee for more than six months of the taxable year; and
• an individual who can be claimed by the employee as a dependent under Code Section 152, who is physically or mentally incapable of caring for himself or herself, and who has the same principal residence as the employee for more than six months of the taxable year.

Eligible Dependent Care Expenses
Reimbursable Dependent Care expenses include:

• in-house child care provider;
• day care centers (if a center provides care for more than six people, it must meet all state and local laws);
• nursery schools, pre-schools or similar programs below the level of kindergarten;
• before- and after-school care programs;
• in-home care for a family member deemed incapable of self-care;
• housekeepers, if a portion of the services are provided for the well-being and protection of a qualifying individual; and
• summer day camps for qualifying individuals (overnight camp expenses are not eligible)

Ineligible Dependent Care Expenses
Dependent Care expenses not eligible for reimbursement include:

• weekend babysitting that is not work-related;
• nursing home expenses;
• transportation expenses, except for transportation by a dependent care provider of a qualifying individual to or from a place where care of a qualifying individual is provided;
• amounts paid to an immediate family member under age 19 or to another dependent; and
• summer school and tutoring programs.

Federal Dependent Care Tax Credit
There are two ways to save federal income taxes when paying for day care: your Dependent Care FSA and the federal dependent care tax credit. There are limits on how the two can be used together.

The expenses you can apply toward the federal dependent care tax credit (up to $3,000 for one qualifying individual, up to $6,000 for two or more qualifying individuals) will be reduced by any Dependent Care FSA reimbursements you receive.
The best approach for you depends on your income and tax filing situation. Consult with your tax advisor for further assistance.

How to Receive Payment from Your Health Care FSA

When you have an eligible expense, the process used for receiving reimbursement depends on whether you use your FSA debit card or submit expenses directly to the FSA claims administrator, Your Spending Account.

Only expenses incurred while covered during the Plan Year and after your enrollment date are eligible for reimbursement.

Reimbursement Options – Automatic Reimbursement and Debit Card

When you enroll in the Health Care FSA you will be offered the opportunity to elect one of two options for reimbursement.

- **Automatic Reimbursement** - Automatic reimbursement allows participants in Liberty Mutual’s health care plans (Medical (including prescriptions), Dental and Vision Care) to be directly reimbursed for eligible out-of-pocket expenses.

- **Your Spending Account Card (YSA Card)** – An FSA debit card that you may use to pay for eligible health care items (see “FSA section” for more details)

With Automatic Reimbursement, you’ll pay your provider out of your pocket at the time you incur an eligible expense. The Liberty Mutual health care plan administrator will then submit the expense to YSA, who in turn will reimburse you directly by check or direct deposit to your bank account. There is no need to submit receipts for substantiation with the Automatic Reimbursement option. However, it is important to save your receipts. Only expenses incurred under a Liberty Mutual's health care plans are eligible for the Automatic Reimbursement option.

Each year after you make your election during Annual Enrollment, you will have the ability to switch between the YSA card and Automatic Reimbursement one time during the plan year. If you switch your reimbursement option during the plan year, you may not switch back to your original reimbursement option until the following year’s Annual Enrollment period. Once you select Automatic Reimbursement, your YSA card becomes inactive.

**FSA Card**

Once you enroll in the Health Care FSA, you will receive a FSA card. The FSA card is mailed to your home address shortly after you enroll in the Health Care FSA. When you receive your FSA card, you must activate the card and you may select an optional pin number by calling the phone number on the card carrier. The card may be used as either a credit or debit card at point of sale.

The card provides you with a way to access funds from your Health Care FSA at the time of purchase rather than paying for an eligible expense out of your pocket and filing a claim after to receive reimbursement. When you are purchasing eligible items along with other items, pay for the eligible items with the FSA card and use a different form of payment for the other items.
• **Purchase only eligible items with your FSA card.** You can find a partial list of eligible FSA expenses in this Summary Plan Description and on the Your Spending Account website accessed through Your Total Rewards website.

• **Save your purchase receipts.** You may need your receipts to substantiate a purchase if requested to do so.

• **Have an alternative form of expense payment ready.** Be prepared with an alternative form of payment such as cash, personal check, or credit card when attempting to make a purchase with your FSA card. Some merchants that sell eligible items and services are not “recognized,” per Internal Revenue Service (IRS) regulations, as qualified merchants by the FSA card transaction authorization process. In these cases, you can pay for the eligible item or service using another payment method and submit a claim for reimbursement. To see a list of merchants who are, or are soon to be, compliant with the IRS-regulations, go to the Your Spending Account website through Your Total Rewards website.

• **The card cannot be used to pay in advance.** This means you cannot provide the card to a vendor who intends to charge you up-front for services to be provided over the course of treatment, for example, the subsequent month. You can, however, use the card to pay for services you have received in full.

• **Keep track of your Health Care FSA account balance by visiting the YSA website.** Try to use all of your contributions by the end of the plan year as a minimum of $50 up to a maximum of $500 may be carried over to the next year. Also, if you do not have sufficient funds in your account, your transaction will be denied at the point of purchase.

• **Provide your home zip code to the merchant if asked.** Using your home zip code helps prevent unauthorized use of your card.

• **Provide your e-mail address.** Login to the YSA website through Your Total Rewards and provide your e-mail address to make communicating with you about your FSA account much faster.

• **Sign up for text alerts on the YSA website to get up to date information about your account sent to your cell phone.**

You may be asked to substantiate some FSA Card purchases. Substantiation means presenting the receipt for an FSA card purchase to prove the eligibility of the purchase. Even though your card swipe is approved at the time of your purchase, you may still need to verify that the money was used for an eligible expense, which means you must save your itemized receipt. FSA card swipe transactions, like standard credit card transactions, often do not provide the details of the purchase. The IRS requires substantiation of purchases by presenting the receipt when the eligibility of the purchase cannot otherwise be substantiated. If your purchase requires substantiation, YSA will contact you and ask you to complete a short form and to submit your itemized purchase receipt along with the completed form.

If you are asked to substantiate your purchase, go to the Your Spending Account website through Your Total Rewards, where you can upload your receipts or get instructions for faxing or mailing your receipts. You may also submit receipts via the free “Reimburse Me” mobile app. If you do not respond to a request to substantiate your purchases, your account will be considered in overpayment status. Your FSA card will be suspended, and you will be moved to the Automatic Reimbursement option. Claim information received from your health plans will be used to offset your outstanding overpayment. When your overpayment has been recovered, you may reactivate your Card by visiting the Your Spending Account website or you can continue in the Automatic Reimbursement option until your account balance is exhausted.

Your FSA card should only be used for eligible purchases that are incurred in the current Plan year. For example, if a prescription is filled at the end of the calendar year, but you do not pick up the prescription and pay for it until the beginning of the next year, you should not use your FSA card. The incurred date for this claim is in the previous Plan Year, while payment is in the current Plan Year. In this case, use an alternative form of payment (other than your FSA card) for your prescription at the point of purchase and submit a Health Care Spending Account Claim.
to YSA along with your original receipt. See below for details on claim form submissions.

Over-the-counter (OTC) medicines and drugs (such as allergy medicines, antacids, pain relievers, or cold medicines) are reimbursable ONLY if prescribed by a physician or if the OTC drug is insulin. You will be required to submit a paper claim and the prescription from the physician to receive reimbursement for OTC medicines and drugs. These items can also be purchased by using your FSA card, provided that you obtain a prescription for the medicine or drug, present the prescription to the pharmacist, the pharmacist assigns an Rx number, and dispenses the medicine. A comprehensive list of OTC items can be found on the Your Spending Account website through Your Total Rewards.

Lost FSA Cards
If your FSA card is lost or stolen, please call Benefits Express at 1-800-758-4460 immediately. If you are calling after normal service center hours, you may call 1-866-438-5797. Service Center Representatives are available to assist you between 8:00 a.m. and 8:00 p.m. Eastern time, Monday through Friday (excluding applicable holidays). After normal business hours, you may call 1-866-438-5797 to report a lost or stolen card.

Submitting Claims
If you do not use your debit card for your purchase and have not enrolled in the Automatic Reimbursement option, you will need to submit a Health Care Spending Account Claim Form to YSA along with your original bill or receipt. If you are requesting reimbursement for deductible, coinsurance, or co-payment amounts, send a copy of the Explanation of Benefits (EOB) that you receive after submitting medical, dental, or vision care claims under your health plan. Original coinsurance or co-payment receipts (cancelled checks are not acceptable receipts) may also be submitted.

Claims forms are available on the Your Spending Account website accessed through Your Total Rewards. For fastest processing, you may upload your claim and supporting documentation directly on the website, or via the free mobile app, “Reimburse Me,” which can be downloaded from your app store. You may also submit your claim form via YSA’s toll-free fax at 1-888-211-9900. If you choose to mail your form, send it to: Your Spending Account, P.O. Box 785040, Orlando, Florida 32878-5040.

If submitting an original bill from the provider, it should include the following information: dates of service, service performed, person receiving the service, the provider’s name, cost, and payments made by the employee. Detailed information on submitting a claim form is included with the claim form itself. Please read the information carefully to ensure that your claim can be processed.

If submitting a claim for an eligible, nonprescription drug (such as allergy medicine, antacid, pain reliever, or cold medicine), you must include the original receipt showing the over-the-counter medication’s name and cost along with a copy of the prescription from the physician. If the purchase was made with a credit card, the credit card used must be in your name or an eligible dependent’s name. If the receipt does not have the medication’s name imprinted on it, please enclose other proof of the medication name.

With the Health Care FSA, you can receive full reimbursement of an eligible health claim at any time during the year, as long as it is not more than your annual contribution, reduced by claims previously reimbursed.

Reimbursement will occur directly to your personal bank account if you have provided this information when you set up your YSA account on the Your Spending Account website. You can setup direct deposit on the Your Spending Account website by clicking on the “Your Profile” link. If you do not choose this method of reimbursement, a paper check will be mailed to your home address.

If your claim cannot be processed due to insufficient documentation or insufficient information, you will be notified by YSA of the additional information that is needed.
How to Receive Payment from Your Dependent Care FSA

When you have an eligible expense:

- You first pay for the expense. Only expenses incurred while covered during the Plan Year and after your enrollment date are eligible for reimbursement. An expense is treated as "incurred" for this purpose when the care is actually provided, not when the participant is billed or pays for the care. For example, when you pay for five days of day care on a Monday, you are pre-paying for those five days. You must wait until after the Friday of that week to submit your claim.
- Claims forms are available on the Your Spending Account website accessed through Your Total Rewards. For fastest processing, you may upload your claim and supporting documentation directly on the website. You may also submit your claim form via YSA’s toll-free fax at 1-888-211-9900. If you choose to mail your form, send it to: Your Spending Account, P.O. Box 785040, Orlando, Florida 32878-5040.
- Provider Certification: You may submit a “provider certification” form which allows the provider’s signature in lieu of receipts. The Reimburse Me mobile app allows the provider to sign your smart phone screen directly which eliminates the need to submit additional documentation.
- If you are submitting a day care provider’s bill, the bill must include the provider’s name and Social Security (or tax identification) number, along with the dates of service, cost, and name of dependent receiving the service. Lunch fees or activity fees are not eligible services.
- With the Dependent Care FSA, you can receive reimbursement only up to the amount that has accumulated in your account at the time you submit your claim.

Run-Out Period for Submitting Claims

Generally, if you are an active employee, you have a three-month “run-out period” during which you may submit claims incurred during the previous Plan Year. That means that your claims must be received by YSA no later than March 31 of the following calendar year. There are important exceptions, however, as described below under the following headings: “Changing Your Contributions,” “Termination of Employment,” and “Right to Continue Coverage.”

Changing Your Contributions

In general, you may not start, stop, or change your FSA contributions outside of the annual Benefits Enrollment period, unless you have a Qualified Status Change.

Eligible employees who during the plan year become benefits ineligible because they are scheduled and regularly working less than 20 hours per week, will no longer be able to contribute to the Plan.

Health Care Flexible Spending Account

You may increase, decrease, start or stop your contributions if you get married or enter into a Domestic Partnership. You may decrease your contribution to $0 for the rest of the Plan Year in the case of the death of a dependent or spouse. You will have thirty (30) days from the date of marriage, entering into a domestic partnership or from the date of death to request a status change via Your Total Rewards. No changes will be allowed after the 30-day period ends. The reduction to $0 will be made as soon as administratively possible, but generally will take effect with the second paycheck you receive after you provide notice.

If you go out on an approved leave of absence during the plan year, your Health Care Flexible Spending Account will continue as though you are an active employee. If your pay is insufficient to cover your Health Care Flexible Spending Account deductions or if your leave is unpaid, you will be billed at your address on file by Home Office Dover Payroll. Employees taking an approved leave of absence have the option of continuing or deferring
participation under the Health Care Flexible Spending Account during their leave. Employees who wish to defer participation must contact Benefits Express before the leave begins. Upon returning from the leave, an employee who has deferred participation may reinstate contributions at the same level he/she had prior to the leave. No reimbursement claims will be paid if incurred during the deferral period. For example, an employee elects to contribute $1,200 to his Health Care FSA per year. He works the first three months of the year and makes $300 in contributions to his Health Care FSA. He then takes a three-month approved leave of absence and defers his election, making no contributions to his account during this period. When he returns from the leave, he has the right to resume participation at the level in effect before the leave (i.e., $1,200). He may make up the unpaid contributions ($300), or resume participation at a level that is reduced on a pro rata basis for the period during the leave for which no premiums were paid (i.e., reduced for three (3) months or one fourth of the Plan year) minus prior reimbursements (i.e., $0) with contributions due in the same monthly amount payable before the leave (i.e., $100 per month). If the employee chooses to resume participation at the level in effect before the leave, his Health Care FSA amount for the remainder of the Plan year would equal $1,200, and the monthly contributions would increase to $150 per month for the remainder of the Plan year, to make up the $300 contributions missed ($100 per month plus $50 per month ($300 divided by the remaining six (6) months). If he chooses a prorated Health Care FSA amount, the amount for the remainder of the Plan year would equal $900, and he would resume contributions of $100 per month for the remainder of the Plan year. The employee may not submit claims incurred during the three-month period for which he made no contributions.

Dependent Care Flexible Spending Account
You may increase, decrease, start or stop your contributions if you have a Status Change that affects eligibility under the Plan, and your reduction is consistent with that change. You may also enroll in the Plan during a Plan Year if you have a Status Change provided your enrollment is consistent with that change. Status Change events include:

- marriage or divorce or legal separation;
- gaining a dependent through birth or adoption (including any stepchild, foster child, legally adopted child, or a child for whom a court order of custody or guardianship has been obtained);
- death of a spouse or dependent;
- change in your employment status (for example, a switch from benefits ineligible to benefits eligible status);
- change in spouse's employment status; and
- loss of dependent status.

You may also change your contributions to a new amount if you have a change in provider or cost for eligible dependent care services.

You will have (thirty) 30 days from the date of a Status Change to request this change on Your Total Rewards and indicate that you wish to reduce your contribution to $0, or join the Dependent Care FSA. No changes will be allowed after the 30-day period ends. If you are out on disability or leave because you have had a baby, you have thirty (30) days from the date you return to work to request a status change on Your Total Rewards. The reduction to $0, or start of contributions, will be made as soon as administratively possible, but generally will take effect with the second paycheck you receive after you provide notice. If you reduce your contributions to $0, you may continue to submit claims after your contributions stop (subject to Plan deadlines). Eligible claims will be reimbursed up to the amount remaining in your account.

If you go out on a leave during the plan year, your Dependent Care Flexible Spending Account will end on the effective date of your leave. Any expenses incurred during the time you are on a leave are considered ineligible. If you return from a leave prior to December 1 in the same plan year in which your leave began, you will have
thirty (30) days to re-elect a Dependent Care Flexible Spending Account for the rest of the plan year. If you return from a leave in a new plan year or during the Annual Enrollment period, you have thirty (30) days to contact Benefits Express to elect a new goal amount for the new plan year.

**Termination of Employment**

**Health Care Flexible Spending Account**

If you terminate employment for any reason including retirement, your claim for reimbursement of any eligible expenses you have incurred prior to termination must be received by YSA by March 31, 2018.

If you have a positive balance in your account (premiums paid through your termination date exceed covered expenses incurred prior to that date), you may elect COBRA coverage for the Health Care FSA and continue your participation for the remainder of the Plan Year in which the COBRA qualifying event occurred as if you were never terminated. Your cost for this continued coverage will be 102% of your prior contribution amount, payable monthly on an after-tax basis.

Any carryover FSA dollars will be available to COBRA qualified beneficiaries for a period of 18 months from the COBRA qualifying event.

Your enrollment will be automatic for the carryover FSA (for qualified beneficiaries who choose to continue the elected salary reduction amount for the Health Care FSA under COBRA or for qualified beneficiaries who do not have a current elected salary reduction amount for Health Care FSA).

You will not need to take any action to continue the carryover FSA amount under COBRA. If you wish to decline or opt out, you will need to contact YSA.

If your employment ends and you are reinstated within thirty (30) days of your termination date, your participation in the Health Care FSA will automatically be reinstated. Your contribution rate will be recalculated for the remainder of the year so that the contributions made prior to termination plus the contributions made after reinstatement total the FSA contribution you elected at Annual Enrollment or for employees hired during the calendar year, the election made at time of hire. Expenses may be submitted for the period between termination and reinstatement.

**Dependent Care Flexible Spending Account**

Your contributions cease upon termination of employment. You may continue to submit claims through the end of the Plan Year for expenses incurred prior to your termination and you will be reimbursed up to the amount remaining in your account. You may not continue to contribute to the Plan after termination of employment.

If your employment ends and you are reinstated within thirty (30) days of your termination date, your participation in the Dependent Care FSA will automatically be reinstated. Your contribution rate will be recalculated for the remainder of the year so that the contributions made prior to termination plus the contributions made after reinstatement total the FSA contribution you elected at Annual Enrollment. For employees hired during the calendar year, this is the election made at time of hire. Expenses may be submitted for the period between termination and reinstatement.
Qualified Medical Child Support Order (Health Care Flexible Spending Account Only)

A "Qualified Medical Child Support Order" may require benefits for a dependent child under the Health Care FSA. Generally, this is a judgment, decree, or order that pertains to divorce. You can obtain a copy of the Plan’s QMSCO procedures by calling Benefits Express at 1-800-758-4460.

Right to Continue Coverage (COBRA) (Health Care Flexible Spending Account Only)

In certain circumstances (for example: divorce, the employee's termination of employment, or death) the employee or his or her spouse and dependents may be entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to elect to continue coverage under the Health Care FSA that otherwise would have terminated, for the remainder of the Plan Year in which the COBRA qualifying event occurred. Please see the section entitled “Right to Continue Coverage” for more information on COBRA coverage. Under COBRA, the employee or other eligible individual must notify the Company within sixty (60) days that a qualifying event has occurred. Such notification (“notification date”) will have important consequences on the operation of the Health Care FSA.

Once the Company is notified of a qualifying COBRA event the employee, spouse, and dependents will have until the end of the plan year to submit for reimbursement any covered expenses incurred prior to the notification date. If a spouse or dependent elects COBRA coverage, and that coverage takes effect after the first day of a Plan Year, the level of coverage available to the spouse or dependent (if any) will be equal to the employee's level of coverage immediately prior to the notification date reduced by covered expenses reimbursed prior to the notification date. The cost of COBRA coverage for the balance of the Plan Year will be equal to the coverage level, determined in accordance with the preceding sentence, multiplied by 102%. The contribution is payable monthly on an after-tax basis.

Expenses will not be reimbursed until any required contribution has been received.

It is important that both you and your spouse read this summary. These provisions generally explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The federal law known as COBRA requires most employers sponsoring group health plans to offer employees and their families who would otherwise lose group health plan coverage a temporary extension of coverage under the employer’s group health plan. COBRA continuation coverage is continuation of Plan coverage when coverage would otherwise end because of a qualifying event, specified below. COBRA continuation coverage must be offered to each person who is a qualified beneficiary, defined as a person who will lose plan coverage because of a qualifying event.

COBRA continuation coverage for the Plan is administered by Benefits Express, Liberty Mutual PO Box 0982 Carol Stream, IL, 60132-0982, telephone number: 1-800-758-4460.

Employee

Employees covered by the Health Care FSA will become qualified beneficiaries and can elect COBRA continuation coverage if coverage is lost because of a reduction in hours of employment or termination of employment (for other than gross misconduct). Benefits Express, as COBRA administrator, will notify the employee whose coverage would otherwise end because of such a qualifying event that the employee has sixty (60) days to inform Benefits Express of his or her intent to elect COBRA continuation coverage. An employee must elect COBRA continuation coverage following such a qualifying event within sixty (60) days of receiving notice of his or her
COBRA election rights from Benefits Express via the COBRA Enrollment Notice. To elect continuation of coverage, employees may call Benefits Express at 1-800-758-4460 or access the Your Total Rewards website. If the employee does not elect COBRA continuation coverage within sixty (60) days of receiving the COBRA Enrollment Notice from Benefits Express, Health Care FSA coverage will end on the date of the qualifying event.

Spouse and Dependent Children
Dependent spouses and children covered by the Health Care FSA will become qualified beneficiaries and can elect COBRA continuation coverage if coverage is lost because of any of the following qualifying events:

- death of an employee (see “Death of an Employee” below);
- termination of an employee’s employment, including retirement (for other than gross misconduct), or reduction in hours of employment, or movement to benefits ineligibility status;
- divorce or legal separation of the spouse from an employee;
- loss of "dependent" status of a child as defined under the Health Care FSA; or
- entitlement of the employee to Medicare.

Newborns and children placed for adoption with a covered employee during a period of COBRA continuation coverage will be eligible for coverage immediately under a parent’s COBRA coverage as qualified beneficiaries.

Notification
If the qualifying event that will cause a loss of Plan coverage is divorce, legal separation, or a child’s loss of dependent status under the Plan, the employee or a family member must contact Benefits Express within sixty (60) days of such a qualifying event. Supporting documentation may be required. For such qualifying events, and the other qualifying events listed under “Spouse and Dependent Children,” Benefits Express, as COBRA administrator, will then notify the person whose coverage would otherwise end because of such qualifying events that he or she has sixty (60) days to inform Benefits Express of his or her intent to elect COBRA continuation coverage. The qualified beneficiary must elect COBRA continuation coverage following such qualifying events within sixty (60) days of receiving notice of his or her COBRA election rights from Benefits Express. If a qualified beneficiary does not elect COBRA continuation coverage within sixty (60) days of receiving the COBRA Enrollment Notice from Benefits Express, Group Health Care Flexible Spending Account coverage will end on the date of the qualifying event. Pay in lieu of Flexible Time Off accrued will not extend your employment or coverage. To elect continuation of coverage, employees may call Benefits Express at 1-800-758-4460. A qualified beneficiary does not have to give evidence of insurability to continue coverage.

Period of COBRA Continuation Coverage
If coverage continuation is chosen, Liberty Mutual will provide coverage under the Plan that is identical to that provided under the Plan to similarly situated employees or family members.

Qualified persons can continue coverage for the remainder of the Plan Year in which the COBRA qualifying event occurred.

This continuation of coverage may be terminated before the end of the maximum period of COBRA continuation coverage if:

- provision of group health care flexible spending participation to employees ceases; or
- the charge for COBRA coverage continuation is not paid when due.
Cost

In most cases, the charge for continuation of coverage will be 102% of the full cost under the Plans.

Address Changes, Correspondence and Questions

To protect your family's rights when you change your address, notify, in writing, the Liberty Mutual HR Support Center at Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, Massachusetts 02116, Attention: HR Support Center – Mailstop J05H, and, if you are a qualified beneficiary, notify Benefits Express COBRA Department, Liberty Mutual PO Box 0982, Carol Stream, IL, 60132-0982; telephone number: 1-800-758-4460, about any changes in the addresses of you and your family members. You should keep a copy for your records of any such notices. If you have questions about COBRA continuation coverage, contact the Liberty Mutual HR Support Center or Benefits Express at the respective address above, or contact the nearest Regional or District Office of the US Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at http://www.dol.gov/ebsa/.

USERRA: Continuation of Coverage during Military Leave

If you are away from work due to military leave, different rules pertain to continuing your benefits, depending on the length of your leave.

If your aggregate military leave during your employment with the Company is two (2) years or less, Health Care FSA coverage may remain effective and you will be responsible for the cost unless you contact Benefit Express to suspend this benefit before your leave begins. All Plan provisions will apply.

If, and when, your aggregate military leave exceeds two years, you may elect to continue your Health Care FSA coverage for up to twenty (24) additional months, or such time period required under USERRA as amended from time to time; however, you will be required to pay 102% of the full cost to continue coverage. If your military leave ends prior to the expiration of this 24-month period and you are reinstated with the Company, your benefits under the Liberty Mutual Health Care FSA will be reinstated without exclusions or waiting periods.

For enrollment and billing information, contact Benefit Express.

Death of an Employee

In the event an employee dies during the Plan Year, claim forms must be submitted no later than March 31st following the end Plan Year for expenses incurred prior to the employee's death. Any funds remaining in the account after that time will be forfeited unless a qualified beneficiary elects COBRA coverage continuation as provided herein.

Forfeitures

FSAs are generally subject to the IRS “use it or lose it” rule. That is, if you contribute more than you receive in reimbursements in any Plan Year, you must forfeit the difference. However, with respect to contributions made to your Health Care Flexible Spending Account, you may carryover an amount greater than $50 up to a maximum of $500 of the unused amount that you have elected in a calendar year. Carryover amounts will not be determined until 60 days following the close of the carryover period of March 31st. The amount carried over to the following
plan year may be used to pay for or be reimbursed for Eligible Health Care Expenses incurred in the following year. With respect to your Dependent Care Flexible Spending Account, the contributions made in one Plan Year cannot be carried over into other Plan Years. In order to minimize any chance of forfeiture, carefully review your anticipated expenses and choose your salary reduction amount accordingly. Also, keep in mind that you can generally submit claims for any Plan Year during the three-month “grace period” following a Plan Year. This means Your Dependent Care Flexible Spending Account must receive your claims no later than March 31 (or the last business day in March, if sooner) of the following calendar year. However, there are important exceptions, which are discussed under the headings entitled “Changing Your Contributions.”

All forfeitures from all Health Care FSAs will be aggregated by the Company and used to reimburse the Company in the event health care reimbursements for the Plan Year exceed participant contributions for that Plan Year. If any funds remain, they will be used to pay administrative expenses of the Health Care FSA.

Dependent Care FSA forfeitures will also be used first to reimburse the Company in the event dependent care reimbursements for the Plan Year exceed participant contributions for that Plan Year. Any remaining forfeitures will be used to pay administrative expenses of the Dependent Care FSA.

**Eligible Health Care Expenses**

The following is a list of health care expenses currently considered reimbursable by the IRS:

- abortion;
- acupuncture (performed by a licensed practitioner);
- alcoholism or drug dependency (payment to a treatment center);
- ambulance;
- artificial limb;
- artificial teeth;
- birth control pills and devices;
- car controls (special controls for people with disabilities);
- chiropractors (services within scope of license);
- Christian Science practitioners;
- contact lenses and solutions;
- crutches (purchase or rental);
- deductible and coinsurance (balance not paid by other medical insurance);
- dental fees (x-rays, fillings, braces, extractions, false teeth, treatments, etc.);
- eyeglasses (including lenses, frames, exams, and prescription sunglasses);
- fertility (medical expenses related to the treatment of infertility);
• founder's Fee (monthly or lump sum fee to a retirement home - covers portion specifically for medical care);
• guide dog (purchase for blind or deaf) deemed medically necessary by a licensed health care professional;
• health care equipment (not for general use articles of furniture, household items, or appliances);
• hearing aids (including batteries and repair);
• homeopathic expenses (documentation from physician detailing treatment, duration, diagnosis and description of medical condition required);
• hospitalization (including private room coverage);
• insulin;
• laboratory fees;
• lead-based paint removal (removal only, not repainting);
• learning disability (tutoring by licensed school or therapist for child with severe learning disability);
• lifetime care (advance payment to private institution for lifetime care, treatment or training of mentally or physically handicapped patient);
• massage therapy expenses (documentation from physician detailing treatment, duration, diagnosis, and description of medical condition required);
• medical information plan (fees paid to a plan maintaining individual's medical information by computer);
• medicines (prescribed and legally obtained drugs and medicines);
• medical services;
• membership fees or costs associated with weight-loss programs for the treatment of medical conditions, including obesity (documentation from physician detailing treatment, duration, diagnosis and description of medical condition required);
• nursing home (confinement for treatment of illness or injury);
• nursing service (by registered nurse or licensed practical nurse for medical care);
• optometrist (services within scope of license);
• orthodontic expenses;
• over-the-counter (OTC) medicines and drugs (such as allergy medicines, antacids, pain relievers, or cold medicines) only if prescribed by a physician or the OTC drug is insulin. A comprehensive list of OTC items can be found on the Your Spending Account website;
• oxygen (to relieve breathing problems caused by medical condition);
• physical therapy;
• psychiatric care;
• psychoanalysis;
• psychologist;
• radial keratotomy;
• schools (medically necessary special schooling to relieve the disability);
• smoking cessation programs and prescribed drugs used to alleviate nicotine addiction (including nicotine patches or nicotine gum purchased to quit smoking);
• sterilization;
• surgery (including experimental procedures);
• telephone (special for hearing-impaired);
• television (audio display equipment for the hearing-impaired);
• therapy (received as medical treatment);
• transplants;
• vitamins and minerals supplements (prescribed for treatment of medical condition and only available by prescription);
• wheelchairs (used mainly for the relief of sickness or disability);
• vaccinations and immunizations; and
• x-ray fees (For medical reasons).

Ineligible Expenses

The following is a list of expenses that are not considered reimbursable by the Internal Revenue Service:

• automobile insurance premiums, including the segment of premiums providing medical coverage for persons injured through accident by an employee's car;
• bottled water;
• cosmetic dentistry;
• cosmetic surgery, including face lifts, etc.;
• cosmetics, toiletries, toothpastes, etc.;
• costs for sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods;
• custodial care in an institution;
• electrolysis;
• expenses incurred in connection with an illegal operation or treatment;
• funeral and burial expenses;
• health club dues, YMCA dues, steam baths, etc.;
• household and domestic help (even if recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework);
• marriage or family counseling;
• maternity clothes, diaper services, etc.;
• membership fees or costs associated with weight-loss programs for general health and well-being purposes, except as noted above;
• naturopathic expenses;
• Over-the-counter (OTC) medicines and drugs (such as allergy medicine, antacid, pain reliever, or cold medicine) purchased without a physician prescription. A comprehensive list of OTC items can be found on the Your Spending Account website;
• premiums paid for life insurance policies, health insurance policies, or for policies providing repayment for loss of earnings or for accidental loss of life, limb, sight, etc.;
• salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (Even though such care may be required due to the death of the mother in childbirth);
• social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
• teeth whitening;
• transportation expenses to and from work, even though a physical condition may require special means of transportation;
• uniforms;
• vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect; and
• vitamins taken for general health purposes.

Consequences of Reimbursement of Non-covered Expenses
In the event of a determination by the Plan Administrator, or by an appropriate governmental body, that reimbursements under the Health Care FSA Plan and/or Dependent Care FSA Plan are taxable to you, you must pay:
• any state or federal income taxes due with respect to these amounts, together with any interest or penalties imposed;
• your share (as determined in good faith by the Plan Administrator) of any FICA or state unemployment benefit contributions that would have been withheld by Liberty Mutual had such amounts been paid to you as taxable cash compensation; and
• an amount (as determined in good faith by the Plan Administrator) equal to the portion allocable to you of any penalties and interest payable by Liberty Mutual as a result of the failure to withhold and pay such amounts to the appropriate payee.
Rights of Plan Participants (ERISA)

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

- Examine, without charge, at the Plan Administrator's office, and at other locations, all documents governing the Plan including the Plan documents 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 copies upon written request to the Plan Administrator of Plan documents governing the operation of the Plan and the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

- Continue FSA participation 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 for the rules governing your COBRA continuation coverage rights, if any.

In addition to creating rights for plan participants, ERISA imposes duties upon the 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, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

Under ERISA there are steps you can take to enforce your rights. For example, you may file suit in a federal court if:

- You have a claim for benefits which is denied or ignored, in whole or in part;

- You request materials from the Plan Administrator and do not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator; and

- The Plan fiduciaries misuse the Plan's money, or you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay the 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 to be frivolous.

If you have any questions, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security 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.

**HIPAA Privacy**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information and to periodically inform you about:

- The Health Care FSA Plan’s uses and disclosures of Protected Health Information (PHI);
- Your privacy rights and the Health Care FSA Plan’s duties with respect to your PHI;
- Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS); and
- The person to contact for further information about the Health Care FSA Plan’s privacy practices.

A description of HIPAA Privacy rights can be found in the HIPAA Notice provided to participants covered under the Health Care FSA Plan. The Health Care FSA Plan and those administering it will use and disclose health information only as allowed by law.

If you have a complaint, question, or concern, or require a copy of the Privacy Notice, please contact the Manager-Benefits Administration, Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, MA 02116, Attention: Benefits Department - Mailstop M03E, telephone: 1-847-224-4767.

*This language is intended to satisfy the notice requirements regarding HIPAA Privacy rights with regards to the Liberty Mutual Health Care Flexible Spending Account Plan.*

**Interpretation of Plan**

The benefit plan Summary Plan Description summarizes the important features of the plan document. While the summary plan description attempts to accurately describe benefits available as of the date of publication, they do not cover every provision of each policy or plan. In the event of a question of interpretation, the wording of the plan document will prevail.

**Administration of the Plan**

**Authority of the Plan Administrator**

The Plan Administrator has the authority, in its sole discretion, to construe the terms of this Plan and decide all questions of eligibility, determine the amount, time and manner of payment of any benefits, and decide any other matters relating to the administration or operation of the Plan. Any such interpretations or decisions of the Plan Administrator shall be conclusive and binding.

**Health Care FSA Claims and Appeals Procedures**

All claims by participants, beneficiaries, and others based on a purported failure to follow the Plan's terms, including, but not limited to, an alleged failure to follow any direction from a participant pursuant to Plan terms, an alleged administrative error or omission, or other alleged misconduct, are subject to the Plan's claims procedures.
You may file claims for benefits with YSA and request a first level review of an adverse claim decisions by YSA and request a second level review of an adverse claim decision by the Plan Administrator, or its designee, either yourself or through an authorized representative, who may be a spouse, parent, or designated health care agent. Inquiries regarding whether certain health care expenses are reimbursable under the Plan are not treated as claims for benefits.

Claim Denial Letters
If your claim is denied in whole, or in part, you will receive a written notice of the denial. The denial letter will contain:

1. the specific reason for the denial;
2. reference to specific provisions on which the decision is based;
3. a description of any additional information necessary to perfect the claim and the reason why such information is necessary;
4. a description of the appeal procedures and time frames, including a statement of the right to bring a civil action under ERISA following an adverse decision on review;
5. the specific rule, guideline, protocol, or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or criterion will be provided free upon request, if applicable; and
6. either an explanation of the scientific or clinical judgment for the determination if the decision was based on a “medical necessity” or “experimental treatment” or similar exclusion or limit, or a statement that such explanation will be provided free upon request.

Appeal Procedures

Appeal Rights
You may submit, and have a right to an appeal review that takes into account, written comments, documents, records, and other information relating to the claim, whether or not such information was submitted or considered in the initial decision. You may request, free of charge, copies of all documents, records, and other information relevant to your claim. You have a right to an appeal review that does not afford deference to the initial denial and that is conducted by a person who is neither the individual who made the initial denial, nor that person’s subordinate. The Plan Administrator, or its designee, in deciding an appeal based on a medical judgment, must consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the denial, nor is the subordinate of any health care professional consulted during the initial claim review. You have a right to the identification of medical or vocational experts consulted in connection with a claim denial, without regard to whether the advice was relied upon in making the decision.

Appeal Time Periods

First Level Review
You must, within one hundred eighty (180) days following receipt of an adverse benefit decision, appeal the decision in writing to YSA. You will be notified of the decision by YSA no later than thirty (30) days for post-service claims after the appeal is received. Please submit your written appeals request to:
The appeal time periods described above begin at the time an appeal is filed, without regard to whether all the information necessary to make a decision on appeal accompanies the filing.

Second Level Review
You must submit a second level appeal in writing to YSA within sixty (60) days following receipt of an adverse first level appeal decision. You will be notified of the decision by the Plan Administrator not later than 30 days for post-service claims after the second level appeal is received. Please submit your written appeals request to:

Claims & Appeals Management
P.O. Box 1407
Lincolnshire, IL  60069-1407

Your request for a second level review will be forwarded to the Plan Administrator for review and determination. The appeal time periods described above begin at the time an appeal is filed, without regard to whether all the information necessary to make a decision on appeal accompanies the filing.

Appeal Denial Letter
The appeal denial letter will contain:

(1) the specific reasons for the adverse decision on appeal;

(2) reference to specific provisions on which the decision is based;

(3) a statement that the claimant is entitled to receive free copies of all documents, records, and other information relevant to the claimant's claim;

(4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures and a statement of the claimant's right to bring an action under ERISA section 502(a);

(5) if applicable, the specific rule, guideline, protocol, or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or criterion will be provided free upon request;

(6) if the decision was based on a “medical necessity” or “experimental treatment” or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free upon request.

Dependent Care FSA Claims and Appeals Procedure
All claims by participants, beneficiaries, and others based on a purported failure to follow the Plan's terms, including, but not limited to, an alleged failure to follow any direction from a participant pursuant to Plan terms, an alleged administrative error or omission, or other alleged misconduct, are subject to the Plan's claims procedures.
If your claim is denied, in whole or in part, YSA will provide you with a comprehensible notice setting forth:

1. the specific reason or reasons for the denial with reference to those specific Plan provisions on which the denial is based;
2. a description of any additional material or information necessary for you to submit to perfect your claim and an explanation of why such material or information is necessary; and
3. a description of the Plan's claim review procedure and time frames, including a statement of your right to bring a civil action following an adverse decision on appeal.

Such written notice of denial will be given within thirty (30) days after the claim is received by YSA unless YSA determines that special circumstances require an extension. In such case, a written extension notice shall be furnished before the end of the initial 30-day period. The 30-day time period may be extended up to an additional fifteen (15) days due to circumstances outside the plan’s control. In that case, you will be notified of the extension before the end of the initial 30-day period. If the extension is necessary because of failure to submit sufficient information, you will be notified of the specific information necessary and given an additional period of at least forty-five (45) days to furnish that information. In such case, the decision-making period is tolled or suspended from the date the extension notice is sent until the earlier of the date the additional information is received or the end of the 45-day period. You will be notified of the claim decision no later than fifteen (15) days after the end of that additional 45-day period or after receipt of the information, if earlier.

The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

First Level Review
If you disagree with a decision to deny the payment of any benefits, in whole or in part, you must submit your appeal, in writing, to YSA, within one hundred eighty (180) days after you receive the notice of denial. You have the right to:

1. submit, for review, written comments, documents, records, and other information relating to the claim;
2. request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
3. a review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision.

You will be notified of the decision by YSA no later than thirty (30) days after the appeal is received. Please submit your written appeal request to:

Claims & Appeals Management
P.O. Box 1407
Lincolnshire, IL  60069-1407

The appeal time periods described above begin at the time an appeal is filed, without regard to whether all the information necessary to make a decision on appeal accompanies the filing.
Second Level Review
You must within sixty (60) days following receipt of an adverse first level appeal decision submit a second level appeal in writing to YSA. You will be notified of the decision by the Plan Administrator no later than thirty (30) days for post-service claims after the second level appeal is received. Please submit your written appeal request to:

Claims & Appeals Management
P.O. Box 1407
Lincolnshire, IL  60069-1407

Your request for a second level review will be forwarded to the Plan Administrator for review and determination. The appeal time periods described above begin at the time an appeal is filed, without regard to whether all the information necessary to make a decision on appeal accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date the Plan Administrator, or its designee, sends you the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

The notice of denial shall include:

(1) the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

(2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim; and

(3) a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

Legal Proceedings
You will not be entitled to challenge a claim decision made by the Claims Administrator in federal or state court or in any other administrative proceeding until all of the Claim and Appeal procedures outlined above have been complied with and exhausted: No lawsuit shall be brought against the Plan, the Plan Sponsor, the Company, the Plan Administrator or the Claims Administrator by you or your authorized representative until:

• the date on which your appeals rights have been exhausted; and
• no more than one year after the time proof of claim is required.

Legal actions are contingent upon first having followed the Claims and Appeals procedure outlined above.

Amendment or Termination of the Plan
The Company can adopt any amendment to the Plan or terminate the Plan at any time. Any action that may be taken by the Company to amend or terminate the Plan may also be taken by the Company’s Chief Executive Officer except as otherwise restricted under the Company’s Compensation Committee Charter.
General Provisions

Each Plan offers participation to employees of Liberty Mutual Group Inc., 175 Berkeley Street, Boston, Massachusetts 02116. The Plans also offer participation to employees of certain United States subsidiaries and affiliates of Liberty Mutual Group Inc. A list of participating subsidiaries is available on request.

The Plan Sponsor is Liberty Mutual Group Inc. The employer identification number assigned by the IRS to Liberty Mutual Group Inc. is 04-3583679. The Plan number assigned in accordance with instructions of the IRS is 508. Plan records are maintained on a calendar year basis: January 1 through December 31, the “Plan Year.”

The Plans are unfunded. Active employee contributions are made on a before-tax basis through the Liberty Mutual Section 125 Plan. Benefits are paid from the general assets of Liberty Mutual Insurance Company.

For purposes of ERISA and the Plans, Liberty Mutual Insurance Company is the Plan Administrator of the Liberty Mutual Employees’ Flexible Spending Account Plans. Aon Hewitt is the claims administrator for purposes of deciding claims for benefits and first level appeals of denials of benefits under the Plan. Your rights under ERISA are described above. As to all other matters, Ms. Melanie M. Foley, Executive Vice President, Chief Talent and Enterprise Services Officer, is designated as agent for service of legal process for the Plan Administrator. Process may be served on her at Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, Massachusetts 02116, Attention: Benefits Department - Mailstop M03E, telephone number 1-617-357-9500.