TASC

Client Administration Manual

HRA

Table of Contents

This Administration Manual provides all of the guidance you need to properly manage your TASC HRA Plan. If you have any questions pertaining to your Plan, call us toll-free at **1-800-422-4661.** For speediest service, please have your 12-digit TASC ID available whenever contacting us.

*Does not apply to Qualified Small Employer HRA

Forms

Please visit www.tasconline.com/tasc-hra-documents to download forms and other documents as needed.

www.tasconline.com/tasc-hra-documents

Welcome

Congratulations on your purchase of a TASC HRA Plan.

As a TASC HRA Client, you are taking part in a benefits program that makes it easy to provide health benefits and to give your employees ultimate flexibility. The materials in this document provide a comprehensive review of the program.

Visit our TASC news site at **www.tasctracker.com** and subscribe to receive news updates via email. Must-know information regarding TASC products is posted regularly on this site.

We look forward to serving you.

WELCOME TO THE PLAN!

HRA

TASC HRA Defined

How TASC HRA Works

A Health Reimbursement Arrangement (HRA) is a Plan funded by you, the employer. Pursuant to the Plan design, you set aside a specific amount annually for employees to use to pay for healthcare expenses. All your contributions to the Plan are deductible and received by the employee on a tax-free basis. By giving the employees more control over their healthcare, they become better healthcare consumers.

The TASC HRA administration service is designed to assist you with the necessary compliance and administration requirements of an HRA. The ever-rising cost of healthcare is most likely a major concern for you. With an HRA Plan, you set aside a specific amount annually for your employees to use to pay for healthcare expenses. The Plan design is very flexible and allows you to offer your employees a wide variety of eligible benefits and reimbursement structures.

As an added benefit, you may choose to allow employees to roll over fund balances at the end of the Plan Year into the following year, thus helping employees prepare for higher-than-expected medical expenses. Often coupled with a High Deductible Healthcare Plan, an HRA allows you to change your employee benefits package while still achieving your goals of lowering health insurance costs or maintaining costs at current levels.

Plan Designs

TASC HRA offers employers Plans designed to work in conjunction with a company-sponsored health insurance plan. An HRA is the right choice for employers who want to allocate a set dollar amount for employees to use on their healthcare expenses, or for employers who offer a Plan that covers a specific type of medical expense such as prescription expenses.

Employers benefit most by switching to an HRA coupled with a high deductible health insurance plan. By designing such a benefits program, their insurance premium will be reduced and the amount saved can be used to establish an HRA Plan.

HRA Plan Designs

Our HRA Plan design offerings are standardized to seven basic types of benefit offerings:

- Deductible Only Expenses
- Deductible/Rx Expenses
- Deductible/ Coinsurance Expenses
- Deductible/Co-pay/Rx Expenses
- Uninsured Medical (213d) Expenses integrated with a health plan
- Deductible/Co-pay/Coinsurance/Rx Expenses
- Qualified Small Employer HRA*

*For small employers (view definition of small employer in box at right) who do not offer a group health plan to any employee, we offer the Qualified Small Employer HRA in which an employer can choose to cover 213d medical expenses and/or medical insurance premiums. These Qualified Small Employer HRA plans still allow for custom configuration as outlined on page 6.

Within those Plan type offerings, there are endless variations of the maximum payout amounts and tier level designations. Explanations of benefits and descriptions of substantiation requirements are as follows:

Deductible and/or Coinsurance
All medical expenses that are applied to the deductible and/or coinsurance of the health plan qualify for reimbursement. Qualified expenses are those incurred by the employee or the employee and family. An Explanation of Benefits (EOB) must accompany all Requests for Reimbursement evidencing the expenses as applicable to the insurance deductible or coinsurance amount.

A small employer is an employer who does not qualify as an Applicable Large Employer (ALE) as defined under Internal Revenue code 4980H rules; please note the determination of whether an employer is an ALE is made on a Controlled Group basis.

Co-pay

All medical expenses that are applied to the co-pay health plan qualify for reimbursement. Qualified expenses are those incurred by the employee or by a member of the employee's family. A copy of a receipt, statement, or Explanation of Benefits (EOB) identifying the claimant, date of service, the amount of the service, the name of the service provider, and description of the service must accompany the Request for Reimbursement evidencing the expenses as applicable to the co-pay expenses.

Uninsured Medical Expenses

All out-of-pocket medical expenses (uninsured costs) qualify for reimbursement. Qualified expenses are those incurred by the employee or the employee and family, if also covered under an employer sponsored group health plan. A copy of a receipt, statement or Explanation of Benefits (EOB) identifying the claimant, date of service, the amount of service, the name of the service provider, and description of the service must accompany the Request for Reimbursement evidencing the expense as an expense applicable to uninsured medical expenses.

When a card swipe is used for these expenses and an IIAS code is obtained, this will meet the substantiation requirements and no additional documentation will typically be required for submission to TASC.

NOTE: Purchases of over-the-counter (OTC) medicines and drugs (other than insulin) will be reimbursable only if accompanied by a prescription or TASC Prescription Order Form signed by your medical practitioner.

Prescription Medication

All prescription expenses that are prescribed by a licensed health provider and are processed through a licensed pharmacy are eligible under the Plan. Covered expenses may or may not apply to the health insurance plan. A copy of a pharmacy receipt must accompany the Request for Reimbursement evidencing the expense as a prescription pharmacy expense. Cash register receipts are not accepted and will be returned to the Participant with a request for the pharmacy receipt.

Submit the HRA Enrollment Spreadsheet by logging into www.tasconline.com and clicking on Contact Us.

Insurance Premiums

A Qualified Small Employer HRA benefit can be used for individual health insurance premiums upon the employee submitting proof of coverage. This benefit does not include medical and dental expenses for any insurance premiums paid by an employer-sponsored health insurance plan. The amount of benefits can vary based on the cost of the health insurance premiums that takes into account age and the number of eligible family members. Payments or reimbursements for the year cannot exceed annual maximum limits.

Enrolling Participants

Eligible employees must determine whether they wish to participate in the Plan. All Participants have the right to opt-out of the HRA plan at each open enrollment and, if retiree benefits are included, when the Participant terminates employment. Once they communicate to their employer's benefits administrator that they wish to enroll in the Plan, the information can be compiled and submitted to TASC via the HRA Enrollment Spreadsheet. It is important that all required information, including the information on a spouse and dependent who are covered under an employer sponsored group health plan, (as indicated on the spreadsheet) is completed prior to submission. If there is missing required data, the spreadsheet will be returned to the Client contact for completion which may delay the enrollment process. Employees not interested in participating should not be included on the spreadsheet; however, the employer should garner an opt out form from these employees, certifying they do not wish to participate. The Client contact for the Plan can submit the HRA Enrollment Spreadsheet by logging into www. tasconline.com and clicking Contact Us. Then follow the prompts for secure submittal.

If you require your eligible Participants to complete an actual enrollment form or are offering the Qualified Small Employer HRA, please use our manual HRA Enrollment Form. To avoid tax issues, Qualified Small Employers should require this form from each HRA Participant; it includes disclosure language and requires validation by the employee of individual health coverage. Once you receive the information on the forms, please transfer the information to the HRA Enrollment Spreadsheet and forward to TASC per the instructions above.

Qualified Small Employer HRA

An employer who is not an Applicable Large Employer (ALE) under the Affordable Care Act, defined as a Small Employer with less than 50 full time employees, who does not offer a group health plan to any employee, can offer a Qualified Small Employer HRA that covers medical expenses as defined by Section 213(d) and premiums for individual health insurance plans. You can design your benefit to include both 213(d) expenses and premiums, or one of these options alone.

This new plan (started in January 1, 2017) repeals the prohibition to offering an HRA Plan without a group health plan. This is the rebirth of the stand-alone HRA plan for Small Employers. For annual limits, please visit our online benefits limits page at https://www.tasconline.com/benefits-limits/.

The Qualified Small Employer HRA has less compliance requirements. The Qualified Small Employer HRA is not a group health plan and is not subject to COBRA.

Qualified Small Employer HRA has three IMPORTANT additional compliance requirements.

1. The law requires the employer to obtain proof that their employees have Minimum Essential Coverage. This is used to determine when the benefits under the Qualified Small Employer HRA are taxable income. The Qualified Small Employer HRA benefits are taxable income for any month in which the employee is not covered under Minimum Essential Coverage. TASC provides a certification on its enrollment form for you to use.

2. The Maximum Benefit under the Qualified Small Employer HRA is reported on the W-2 Form. Check with your tax or payroll advisor to determine how this is reported. If you use the TASC PayPath program, then TASC will report this requirement.

3. There is a notice requirement for every employee who participates. This is a short notice that the employee provides to any health insurance exchange when the employee requests the federal subsidy. The Participant's monthly subsidy is reduced by 1/12 of the HRA benefit. TASC will provide you with a notice to use for this purpose. It is your responsibility to distribute the notice to your employee-Participants. TASC will not be responsible for any excise tax/penalty assessed for late notices.

Plan Funding Arrangement

Plan Funding Arrangement

Unique in the industry and available to Clients only is the TASC Funding Arrangement. This distinctive fund management program allows employers to advance claim payments to employees before the full reimbursement amount is present in their account. TASC and not the employer fronts the necessary funds to reimburse employee claims!

Many TASC HRA Clients use the Funding Arrangement as an effective budgeting tool. Gone are the financial management issues that may arise when the necessary funds must be collected in advance to cover the occasional spike in employee claims. TASC manages claims volatility without disrupting reimbursements to employees.

Establishing the Funding Arrangement

When an employer establishes a an HRA Plan, he/she assumes the risk that all insured may reach Plan maximums; in reality this does not happen often. At the beginning of each Plan Year, a Funding Arrangement amount is established based on an estimated utilization factor. The utilization factor varies depending on the benefits offered and is designed as a floor amount, thus allowing the employer a way to establish their personal comfort level related to Plan risk. Once established, this set monthly amount is transferred from the employer's account directly to TASC via ACH. These funds are used to pay employee reimbursements. TASC will pre-fund Participant claims even when funds are insufficient in an employer's account at the time of the request. If an employer's Plan experiences monthly claims that are less than the monthly funding amount, the fund balance will be held in the employer's HRA account. Conversely, if the monthly claims exceed the funding arrangement amount during a month, those funds will be drawn from the employer's account. If during the year claim utilization exceeds the annual plan funding, TASC reserves the right to require an employer to fund all claims exceeding the annual Plan funding.

When an employer establishes a TASC HRA Plan, he/she assumes the risk that all insured may reach Plan maximums; in reality this does not happen often.

On a quarterly basis, TASC will do an official review of the employer's claim utilization and compare it to the Plan Funding Arrangement. On a monthly basis, TASC will do a quick review to ensure that the Plan is not in a negative balance. At either of these reviews, TASC will determine if there are necessary adjustments to the Plan Funding Arrangement. If it is determined that claims experience exceeds funding received, the Client will receive an email indicating the amount due that will be taken by ACH debit for the difference between claims paid and the funding received. To ensure that you are up-to-date with your current claims utilization status, all employers are encouraged to review the claim history web tools and reports located online. Our easy-to-use web is available for you in real time, 24/7.

Participant Termination

Upon termination, the Client must notify TASC of the termination via a Change Form. Participants will be allowed to submit claims for services incurred prior to their termination date through the Plan's applicable runout period.

TASC HRA Reimbursements

A key element to a TASC HRA is the reimbursement of the Participant's eligible expenses. A Participant may request reimbursement any time a qualified expense has been incurred. The service related to the expense needs only to have taken place; it need not be paid before requesting reimbursement. The Participant may request reimbursement (a) only for eligible expenses incurred during the applicable Plan Year, (b) made by eligible Plan Participants, (c) for expenses which have not been reimbursed previously under this or any other benefit plan(s). It is the Participant's responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible claims. Failure to comply may delay payment.

If claim payments for ineligible expenses or claim overpayments occur, TASC will hold the Participant responsible for reimbursing those amounts. The resolution process can be found in the TASC Service Level Agreement attached to the Plan application.

If an employer has a health Flexible Spending Account (FSA) along with their HRA, certain ordering rules apply. Per TASC's policy, if an expense is eligible for both benefits, the HRA is the primary payer and the healthcare FSA is secondary. The HRA Plan design needs to be considered carefully when determining if an expense is eligible for both benefits.

Request for Claim Reimbursement

Once a request is received, reviewed, and approved, a reimbursement check or direct deposit is issued for the full amount of the claim (based on the Plan design and available funds). The Plan contribution limit is factored in. TASC maintains any reimbursement requests that exceed Plan limitations, and does not notify Participants if they exceed their Plan limit. Any balances in the account at the end of the Plan Year will be rolled over and applied to the following Plan Year (when employer offers rollover feature).

Complete and accurate requests received by TASC prior to noon CST will be processed within 48 hours, with direct deposits initiated the subsequent business day. Checks are mailed out once a week after claims are processed. Actual receipt of the reimbursement depends on the mail and on banking systems. Participants must check with their financial institutions for availability of funds. TASC is not responsible if a Participant's bank account is assessed non-sufficient funds fees when funds to cover pending Requests for Reimbursements are not yet deposited.

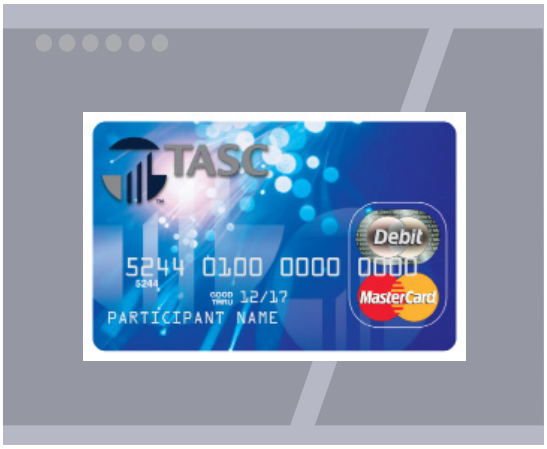
The online Request for Reimbursement form makes the claim submittal process easy, fast, and accurate.

Online Request for Reimbursement Form

A Participant must log in to their MyTASC account and select File A Claim from the home page. Follow the online instructions to enter the claim information and upload the substantiation document for each claim. Multiple claims must not be grouped together as one claim; they must be entered separately. If the Participant is unable to submit their claim(s) online, they may submit a Request for Reimbursement form and substantiation via fax or mail. (Manually submitted claims will require additional processing time.)

Benefits Card (if elected)

After enrollments are complete, each Participant will receive the Benefits Card(s) under separate cover in a plain envelope. Please encourage Participants to watch for this mailing.



Participants may use the Benefits Card for any eligible expenses incurred within the parameters of the Plan and Plan Year dates. In addition, Participants may submit manual claims via an online claim request any time a qualifying expense has occurred (must not have been previously processed through a card transaction).

When using the Benefits Card, the date of service for that charge will be the date of the card swipe.

Substantiation providing date of service and description of service will be required for debit card purchases unless any or all of the following apply to your plan: 1) card is used at merchants that have the Inventory Information Approval System (IIAS); 2) single or combination match of your group health plan co-payment(s), if applicable (not to exceed five times the maximum benefit co-pay); and 3) card is used for recurring, previously approved medical claim (same amount and same medical provider of a subsequent substantiated claim within same plan year). Participants will receive a request for substantiation when required. If debit card substantiation is not submitted within a reasonable time, the Participant's TASC Card will be temporarily deactivated until the matter is resolved.

IMPORTANT regarding payments for previous Plan Year expenses:

- Expense charged to current Plan Year. If using the Benefits Card to pay for a claim incurred in a previous Plan Year, the expense will be taken from the current year Plan balance. For example, for a calendar year HRA Plan, if a Participant uses the Benefits Card on January 15 to pay a medical service provider for an expense that occurred November 15 (of the previous Plan Year), the expense will be deducted from the new Plan Year balance.
- Expense charged to previous Plan Year. Participants should *not* use the Benefits Card, and instead should submit a manual online claim. Doing so will ensure that the expense is reimbursed from the correct Plan Year.

Substantiation and Verification

All Requests for Reimbursement must include a substantiation document. Upon receipt of the request and the substantiation documents, TASC will verify the expense and process the reimbursement. Any request that fails verification will be returned to the Participant.

Substantiation Documents Required

Medical Deductible and/or Coinsurance Expense

An Explanation of Benefits (EOB) must accompany the Request for Reimbursement as evidence that the expense is applicable to the insurance deductible or coinsurance.

Medical Co-pay Expenses

An explanation of Benefits (EOB) or detailed receipt from the health provider identifying the claimant, date of service, amount of the service, and name of the service provider must accompany the Request for Reimbursement.

Uninsured Medical Expenses

A copy of a receipt or bill identifying the claimant, date of service, amount of service, and the name of the service provider is required to substantiate the reimbursement. This may also include an EOB statement. Over-the-counter (OTC) purchases must be substantiated with a prescription or signed TASC Prescription Order Form by a medical practitioner.

Pharmacy

A copy of a pharmacy receipt is required to substantiate the reimbursement. Cash register receipts for prescription expenses are not allowed as substantiation.

Insurance Premiums

A Qualified Small Employer HRA benefit can be used for individual health insurance premiums upon the employee submitting proof of coverage. Payments or reimbursements for the year cannot exceed annual maximum limits.

Claim ConneX Feature

(Does not apply to Qualified Small Employer HRAs)

Claim ConneX is a service option provided by TASC to alleviate the time and labor costs associated with Participant claims processing through our HRA Plan.

Claim ConneX is designed to streamline and simplify the reimbursement process and to reduce workload for all concerned. This electronic auto submittal and auto adjudication of claims comes at no additional cost to the Client or Participant.

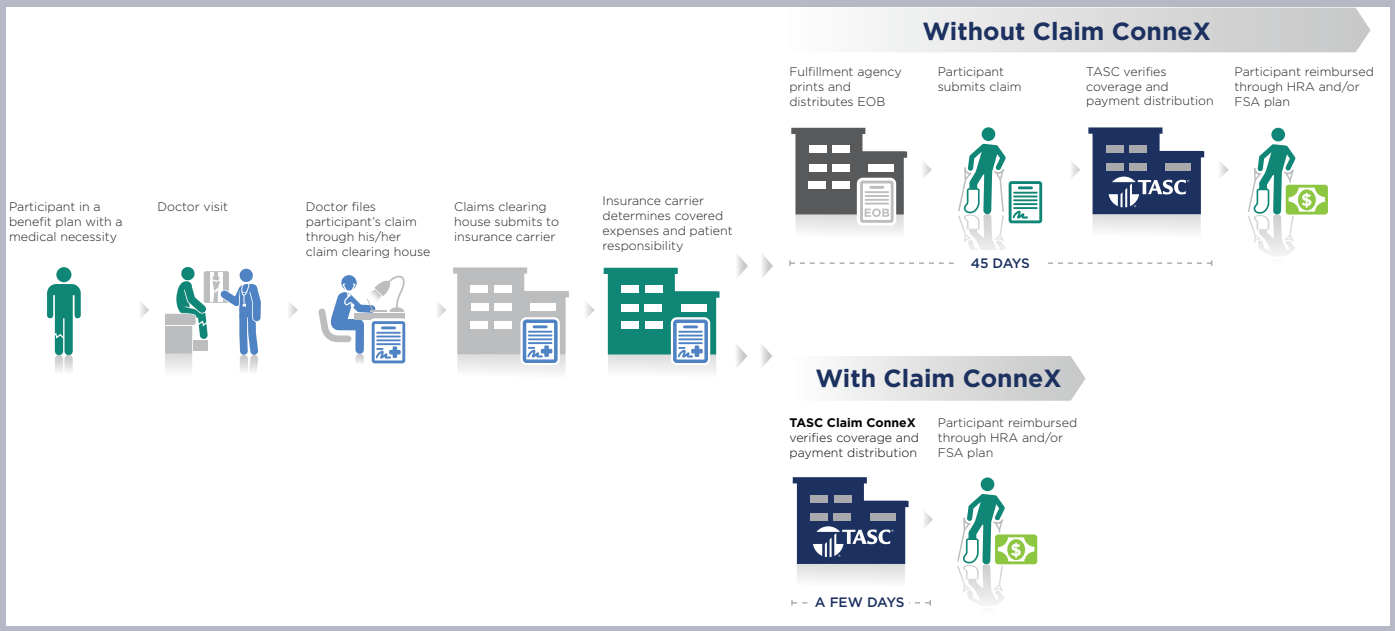
Employers who enroll with Claim ConneX find increased value and Participant satisfaction with the HRA Plan.

How it Works

If your health plan carrier is an active Claim ConneX carrier with TASC,* you will need to communicate to them that you want to have Claim ConneX set up with your HRA Plan. Once the Plan is set up, TASC will receive Participant claims from Claim ConneX through your health plan carrier. Generally, your Participants will not have to submit claims to TASC. However, we do provide Request for Reimbursement (RFR) forms to them in case they have any special circumstances where they need to submit claims manually or they decide to opt out of Claim ConneX (if allowed by the Employer).

Employers who enroll with Claim ConneX find increased value and Participant satisfaction with the HRA Plan as the Participants are not responsible for manual claim submission.

*TASC currently has several health plan carriers that are set up with Claim ConneX. If you do not know if your carrier is eligible, please contact your insurance broker or TASC Regional Sales Director for more information.



(Does not apply to Qualified Small Employer HRAs)

CMS Reporting Requirements

As part of the Medicare, Medicaid, and SCHIP Extension Act of 2007, the Centers for Medicare and Medicaid Services (CMS) require Health Reimbursement Arrangement (HRA) reporting under Section 111. TASC will serve as the Responsible Reporting Entity (RRE) for all eligible HRA Plans.

CMS reporting for HRA Plans is required for those Plans with the following parameters:

- An annual benefit value of $5,000* or more.
- 20 or more employees.
- Employers who participate in a multi-employer Group Health Plan with a combined 20 or more employees.
- Employers who have covered an individual on their Plan who is receiving dialysis or has had a kidney transplant.

Reporting is exempt for HRA Plans with the following parameters:

- An annual benefit value of less than $5,000.
- Less than 20 employees.
- Retirement plans.
- COBRA plans.
- Non-medical plans such as dental and vision plans.

TASC is required to report on any Active Covered Individual who is either:

1) 45 years old or older,
2) Receiving kidney dialysis or who has received a kidney transplant, regardless of their own or a family member's current employment status, or
3) Entitled to Medicare and has coverage based on their own or a family member's current employment status.

An Active Covered Individual is defined as someone who may be Medicare eligible and currently is employed, or an employee's spouse or other family member who is covered by said employee's individual Group Health Plan and who may be eligible for Medicare and for whom Medicare would be a secondary payer.

Along with basis demographic information, we will require the following information to be provided to us so that we can fulfill the requirements of CMS HRA reporting.

- Employee Social Security number.
- Employee date of birth.
- Spouse date of birth.
- Spouse Social Security number.
- Date of birth, Social Security number, and HICN number (if available) for any known dependent that is currently covered by Medicare.

NOTE: While CMS reporting requirements mandate that we include Social Security number and date of birth, this information will not be used for any other purpose and will not be included on any Participant forms we generate.

More information regarding CMS reporting can be found at www.cms.gov.

*The benefit value includes funding deposit amounts rolled over from the previous year's coverage. TASC will provide a limited enrollment version for Qualified Small Employer HRAs in which we don't require the full data set captured for CMS reporting required plans.

Annual Plan Renewal

Annual Plan Renewal

Near the end of the Plan Year, the Employer will receive an email from TASC requesting information on Plan renewal. Refer to your Plan Year Summary Plan Description (SPD) for easy reference to the Plan design. The Employer must review the current Plan Year parameters and submit the completed TASC HRA Renewal Form via an online service request to TASC indicating that the Plan should be renewed with no changes or with indicated changes. Employers should provide renewal information to TASC as soon as possible after they receive their renewal email.

Runout and Forfeiture

The three months following the end of the Plan Year are called the runout period. During this time, employees can continue to submit Requests for Reimbursement for expenses incurred during the previous Plan Year (if they have a positive account balance). The Plan Year is officially closed three months following the end of the Plan Year, or sooner if directed by the employer. Upon the end of the runout, TASC will begin the forfeiture process to reconcile the previous Plan Year's account. The forfeiture process can take up to 60 days following the close of the runout period.

At the end of the Plan Year all funds remaining in an employer's account will be placed in a reserve account. Should an employer's Plan end the Plan Year with a negative account balance, the employer will be invoiced for the amount. This amount may be held to cover any deficits in funding for the new Plan Year, or the Client can request that the funds be released to them at completion of the forfeiture.

Client Plan Timeline

January

- Enrollment for New Plan Year is complete
- Client receives updated Summary Plan Description and Summary of Benefits & Coverage (if required) for distribution to Participants.

April/May

- Previous Plan Year account balances are finalized and closed (within 60 days of close of Plan following Plan runout)

October/November

- Plan Elections are made by the Client.
- Plan Elections are submitted to TASC.
- Client receives their annual renewal invoice.

December

- Verification of Participants' funding arrangement is sent to Client if changes are required for new Plan Year.

** These dates are based on a Plan Year that runs from January 1 through December 31. Those with non-calendar Plan Years should make the appropriate adjustments.*

Internal Revenue Service Form 5500

All employers with 100 or more eligible employees must file IRS Form 5500. Compliance is the employer's responsibility and must be made by the last day of the seventh month after the Plan Year ends. Failure to file the annual return can result in penalties. As part of your support services, we will prepare IRS Form 5500 for you at no additional cost. To request the 5500 form for your TASC HRA Plan, go online to www.tasconline.com/5500 for instructions. A one time extension can be requested by filing IRS Form 5558 by the original due date in order to receive an extension.

Sole Proprietor, Partnership and S-Corporation

Self-employed individuals, including partners in a partnership and more-than-2% shareholders in an S corporation cannot participate in an HRA on a tax-favored basis. A sole proprietor, partnership, or S corporation can have an HRA for its common law employees. But unlike a sole proprietorship or a partnership, neither the employee or spouse of the more-than-2% shareholder in an S corporation, nor that person's children, parents, or grandparents can participate in the S corporation's HRA. This is because of the ownership attribution rules contained in Code §318.

Health Savings Account (HSA)

Employees participating in an Health Saving Account (HSA) through their employer or who have established one on their own can participate in an HRA, if the Plan is set up as a limited purpose or post-deductible HRA. If the HRA is not established as such, the employee is not eligible to participate in an HSA.

Healthcare Benefits for Children Under Age 27

IRS Notice 2010-38, which went into effect on March 30, 2010 dictates that health insurance coverage is extended for employees' children under age 27, and is generally provided for such children on a tax-free basis to the employee.

The Notice provides for employer-sponsored insurance premium costs (of the extended coverage) as well as for medical expenses incurred under a HRA Plan (if applicable under your Plan design). Under the notice, the definition of a child includes a son, daughter, stepchild, adopted child, or eligible foster child (including a child of the employee who is not the employee's dependent). These new age and dependent status changes replace earlier lower age limits and establish that a covered child need not qualify as a dependent for tax purposes.

The exclusion from gross income for premium and medical HRA expenses applies only to an employee's child who has not attained age 27 at the end of the taxable year. For purposes of this Notice, the taxable year is the employee's taxable year; employers may assume that an employee's taxable year is the calendar year and may rely on the employee's representation as to the child's date of birth.

W-2 Reporting of Health Benefits

NOTE: Generally, employers will be required to report the cost of employer-sponsored coverage beginning with the 2012 Form W-2 (filed in 2013). Section 9002 of H.R. 3590 requires employers to calculate and report the aggregate cost of applicable employer-sponsored health benefit coverage on employee IRS Form W-2s. The legislation is effective for tax years beginning after December 31, 2010. All employers who offer employer-sponsored health insurance coverage must comply with this new legislation.

Under the new requirement, costs must be reported for the following plans and services:

- Medical plans;
- Prescription drug plans;
- Executive physicals;
- On-site clinics which provide more than a minimum of care;
- Medicare supplemental policies;
- Employee assistance programs;
- Dental and vision plans, unless they are "stand-alone" plans;
- And, the cost of coverage under HRA Plan.

The aggregate cost of coverage under the plans (including the employee and employer portions of cost) is determined under rules similar to COBRA. Under

the new reporting requirement, employers must establish value for coverage provided by plans and programs not previously valued for COBRA purposes. (Government regulations regarding how to value plans for COBRA purposes are expected shortly. Any regulations issued will apply both to COBRA and to the new IRS Form W-2 reporting requirements.)

For additional clarification on these points you may wish to consult with your payroll professional or health insurance provider.

Annual Limits

One provision of the Patient Protection and Affordable Care Act (PPACA), which went into effect back in September of 2010, prohibits health plans from imposing annual "caps" on the reimbursement of essential health benefits.[1] The interim final regulation provides that for Plan Years beginning before 2014, a group health plan may impose a restricted annual limit on essential health benefits, but only if the annual limit is at least one of the following:

- $1.25M annual limit for Plan Years beginning on/after September 2011 but before September 1, 2012; and
- $2M annual limit for Plan Years beginning on/after September 23, 2012 but before January 1, 2014.

Effect on HRAs

In the same interim final regulation, certain categories of HRAs were declared automatically exempt from the annual limit requirement.

- Integrated HRAs– those that are "integrated" with, or tied to, a high deductible health plan or other health insurance coverage. (Status = EXEMPT)
- Retiree HRAs– those that reimburse only those expenses incurred after the Participant's employment has ended. (Status = EXEMPT)
- Limited Scope HRAs– those that reimburse dental and/or vision expenses only. (Status = EXEMPT)

What does this mean?

From 2014 forward, no annual limits can be imposed on group health plans which fail to meet any of the exceptions.

[1] Essential health benefits that are subject to the restriction on annual limits include the following: ambulatory, emergency, hospitalization, laboratory, maternity/newborn care, mental health/substance abuse, pediatric, preventative/wellness services, and rehabilitative care.

(Does not apply to Qualified Small Employer HRAs)

SBC Requirements

The Departments of Treasury, Labor, and Health & Human Services (HHS) have released regulations regarding the Patient Protection & Affordable Care Act (PPACA) requirement to distribute a uniform explanation of coverage. Per the regulations, group health Plans and health insurance issuers must distribute an easy-to-understand Summary of Benefits and Coverage (SBC). As a self-funded group health Plan, your TASC HRA Plan is subject to the SBC requirements.

TASC will work with you to ensure that your HRA Plan remains in compliance with this important new requirement. Please carefully review the below details to ensure that you are ready for this regulation.

When does this new requirement start?

This requirement begins for the first open enrollment period that commences on or after September 23, 2012. For example, if your Plan renews in October 2012 and your open enrollment commences on September 1, 2012, then you need not provide an SBC during your open enrollment. Conversely, you must provide an SBC to "late" enrollees who enter your Plan after September 23, 2012 as new hires or through special enrollment rights.

How do you obtain an SBC for your HRA Plan?

TASC will provide the SBCs along with your Summary Plan Description for new HRA Plans and at Plan renewals.

Who is responsible for the HRA SBC?

TASC will provide the SBC to the employer, who will be responsible for distribution to the required employees and dependents.

When must you distribute the HRA SBC?

- At open enrollment (renewal): If you distribute written materials for enrollment (in paper or electronic form), the SBC must be provided as part of those materials. If no HRA materials are distributed, then the SBC must be provided no later than the first date a Participant is eligible to enroll in coverage.
- At special enrollment: Within 90 days after special enrollment; this rule applies to the Summary Plan Description as well.
- On request: No later than seven business days after request.

Who needs to receive the HRA SBC?

Every employee, spouse, and dependent enrolled in or eligible to enroll in your HRA Plan. In contrast, the Summary Plan Description (SPD) is required only for persons who actually enroll/re-enroll (renew) in your HRA Plan. One HRA SBC mailed to the employee's last known address will suffice (covers everyone who is eligible in the employee's family) unless you have information that a Plan-eligible family member does not reside with the employee.

Can you disseminate the HRA SBC by electronic means?

The same Department of Labor rules that are used for your Summary Plan Description and other ERISA documents apply. In summary, if you provide the SBC by Internet posting, you must also distribute a paper notice or email notice of the availability. Besides detailing the Internet address, the notice must indicate that the SBC is available in paper form on request.

Are you required to provide the HRA SBC in another language?

If the SBC is distributed to residents of a county wherein 10% or more of the population is literate in the same foreign language only, then the SBC must include a notice that interpretative services are available. For a list of counties in which this is required go to www.cciio.cms.gov/resources/factsheets/clas-data.html.

What happens if you do not provide the SBCs?

Federal regulators have published a good faith compliance standard for the first year, stating that they will not penalize employers who work diligently to provide the SBCs. After the first year, or for employers who fail to meet the good faith standard, (a) a $1,000 per year penalty per enrollee shall apply for willful failure to provide the SBC and (b) a $100 per day excise tax shall apply for each person who is not provided with an SBC.

If you have any questions or concerns regarding this new requirement, please contact Customer Care.

Determining COBRA Premiums

(Does not apply to Qualified Small Employer HRAs)

Pursuant to the Employee Retirement Income Security Act (ERISA), a Health Reimbursement Arrangement (HRA) is a group health plan subject to the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act (COBRA). As a general rule, employers subject to COBRA are those with 20 or more employees during the preceding calendar year.

Employees experiencing any of the following qualifying events must be given the opportunity to continue participation in the HRA offered by the employer:

- Voluntary termination.
- Involuntary termination.
- Reduction in hours.
- Death of an employee.
- Divorce or legal separation.
- Employee's Medicare entitlement.
- Dependent child ceasing to be a dependent.

The number of months that the employee may continue participating in the HRA via COBRA depends upon the qualifying events. Continuation may last anywhere from 18 to 36 months.

When a qualifying event occurs, each qualified beneficiary who loses coverage has a separate and independent right under COBRA to continue the HRA coverage amount that was available immediately preceding the qualifying event. Furthermore, while the qualified beneficiary is on COBRA, his or her coverage amount is increased "at the same time and by the increment that it is increased for similarly situated non-COBRA beneficiaries (and by decreasing it for claims reimbursed).

COBRA defines "applicable premium" as the cost to the Plan of providing coverage to similarly situated beneficiaries who have not experienced a qualifying event. The applicable premium must be determined prior to each 12-month determination period. For self-insured plans (such as most HRAs), the premium must be actuarially determined or, alternatively, the applicable premium may be determined by using a "past-cost" method. A Plan is permitted to charge a qualified beneficiary up to 102% of the applicable premium.

Under the actuarial method, the applicable premium shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which is determined on an actuarial basis, and takes into account such factors as the Secretary may prescribe in regulations.

Under the past-cost method, the applicable premium equals the cost to the Plan for similarly situated beneficiaries for the same period occurring during the preceding determination period adjusted by the percentage increase or decrease in the implicit price deflator of the gross national product. The past-cost method cannot be used in any case in which there is any significant difference between the determination period and the preceding determination period, in coverage under, or in employees covered by, the Plan.

Past-Cost Method Example:

Calculate the liability from the previous Plan Year:

- 10 Single Employees x $1,000 max reimbursement.
- 10 Family Employees x $2,000 max reimbursement.
- $30,000 maximum liability.
- Claim experience: $15,000 total paid out
- 50% utilization.

Apply the utilization to the new Plan Year:

- Single Employees: $1,000 max reimbursement x 50% utilization = $500 annual COBRA premium x 2% COBRA administration fee.
- Family Employees: $2,000 max reimbursement x 50% utilization = $1,000 annual COBRA premium x 2% COBRA administration fee.

New HRAs cannot use the past-cost method (they have no past cost for a prior year) and must use the actuarial method instead.

For a new HRA, those who do not wish to retain an actuary might consider it to be a reasonable estimate of the cost if one relies on the first-year experience that other HRAs have had. (For example, a third-party administrator (TPA) like TASC with considerable HRA experience might advise an employer that, on average, 25% of the available reimbursement dollars are used up during an HRA's first year (ignoring any administrative costs). Based on this advice, it might be reasonable to estimate that, for an HRA with a $1,000 annual accrual, the COBRA applicable premium for the first year will be $250. The maximum COBRA premium that could be charged would be $255, which is 102% of the applicable premium.)

Below is the utilization experience of HRA plans. Employers can use these utilization amounts and apply them to their own maximum benefits for the first year of the HRA Plan and then move to the past-cost method for subsequent Plan Years.

- Medical Deductible Only: 25% Utilization.
- Medical Deductible, Rx, Coinsurance, Copay or any combination: 50% Utilization.
- Uninsured Medical Plans: 50% Utilization.

Manage Users and Plan Administration

As an employer, you have a separate web page to access your user accounts and invoices, and to submit a service request. Follow the easy instructions below for logging into the website.

Logging In to MyTASC

You must have a valid email address on file with us to access MyTASC. You will receive an email containing user TASC ID and a link to help you access MyTASC the first time and prompting you to set a password. If you do not receive this email message, please call Customer Care.

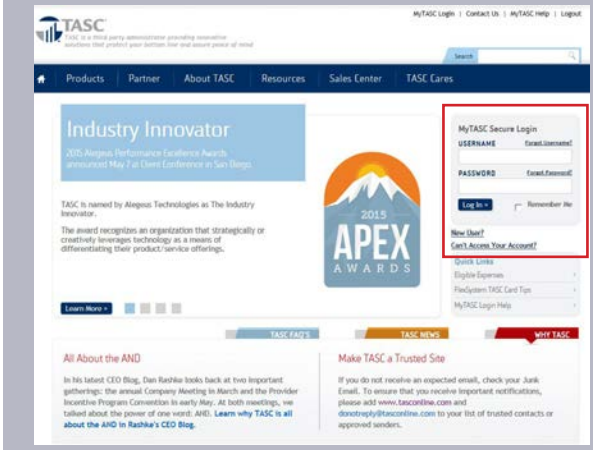
i. Visit www.tasconline.com

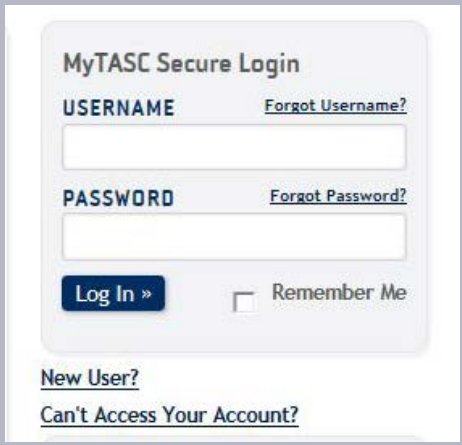
ii. Click on MyTASC Secure Login on the right side of the page.

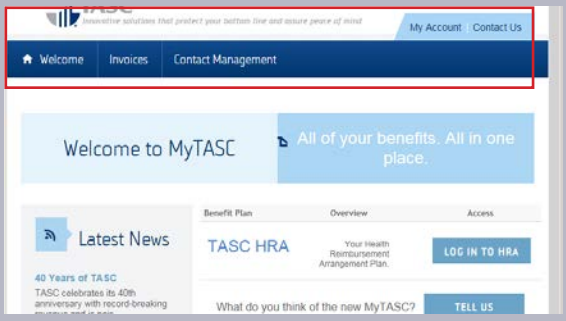
iii. Enter your username (or your TASC ID) and password (if you do not know your password, click Forgot Password).

iv. Click Log In.

v. You will receive a security message the first time you log in. After you review the information, click OK.







From MyTASC, you can manage your user accounts, invoices, and service requests.

NOTE: All Clients and Participants are obliged to maintain up-to-date contact information in MyTASC; this includes email and mailing addresses, and phone numbers. TASC periodically sends important Plan notifications (regarding balances, deadlines, and/or Plan changes). We are not responsible for any consequences resulting from communications not received due to inaccurate contact information.

Changing your MyTASC Username

i. Click Contact Management (from the blue bar on your MyTASC homepage).

ii. Click Manage Contact.

iii. Click Access

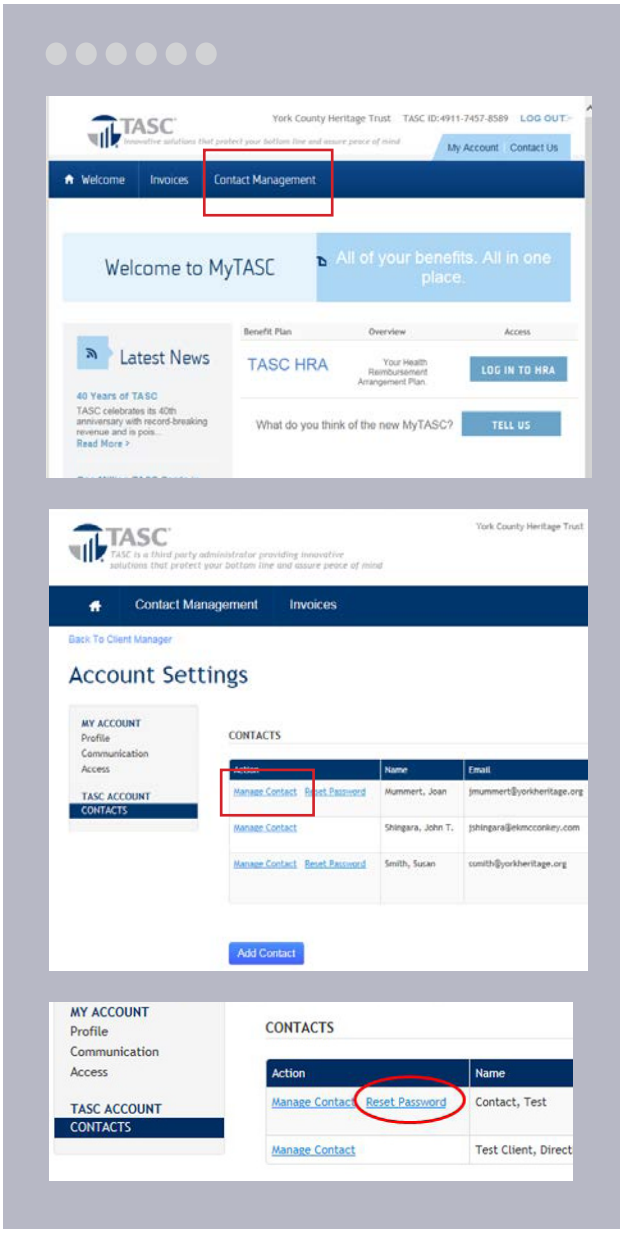
v. Update Username

* Your username must be at least 10 characters. We recommend using your email address.

Resetting your MyTASC Password

i. Click Contact Management on your homepage, then locate the User and click Reset Password.

ii. You will receive an email token with instructions.



Manage User Accounts

With MyTASC, you can enter multiple contacts and different contact types, as well as email addresses for each contact.

To add a contact in MyTASC:

a. Click Manage User Accounts on your Client Manager home page.

b. In Contacts, click Add Contact.

c. Enter the contact's general information.

d. Click Submit and set the applicable Contact Preferences.

e. Click next and select if this contact should be allowed to log in.

f. If the contact will log in, select a Username (10 digits or an email address) and the contact role(s). Select Submit.

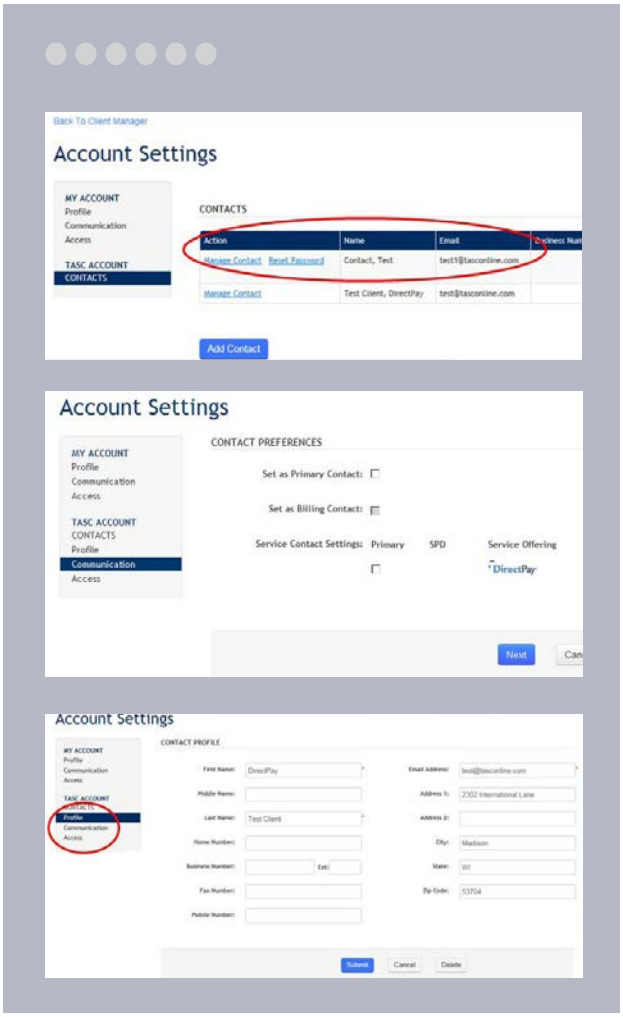
To edit contact information in MyTASC:

a. Click Manage User Accounts on your Client Manager home page.

b. In Manage User Accounts, click on the Manage Contact link for the person you wish to edit.

c. Edit the Profile, Communication or Access information for the contact.

d. To delete a contact, click the Manage Contact link for the contact and click Delete.



Invoices

View and print your administration fee invoices.

a. Print a Statement

- Select the Print a Statement link.
- Enter the Statement Date.
- Choose to show only open transactions or to show a consolidated statement.
- Select Print.
- Select the home link to return to the Invoice Home page.

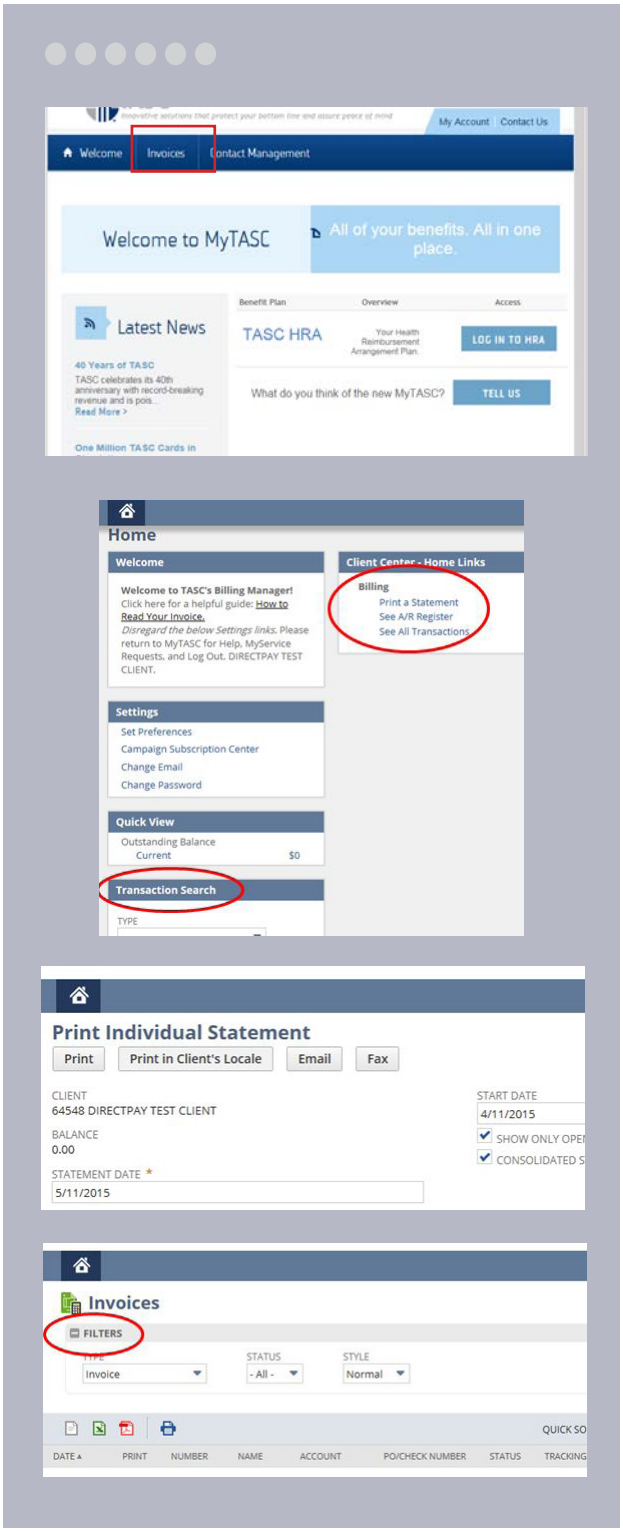
b. View Transactions

- Select the See All Transactions link.
- Click the "+ Filters" at the top left of the screen and select the Type and Status to refine your view.
- Select the home link to return to the Invoice Home page.

c. Search for a specific invoice or payment

- Under Transaction Search, select the type from the drop down and enter in the invoice or payment information in the applicable fields.
- Click Search.

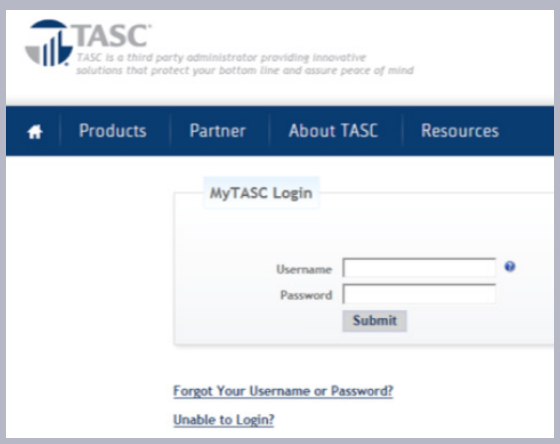
d. Exit the invoice portal by clicking the red x in the top right corner of the page. This will take you back to your MyTASC home page.



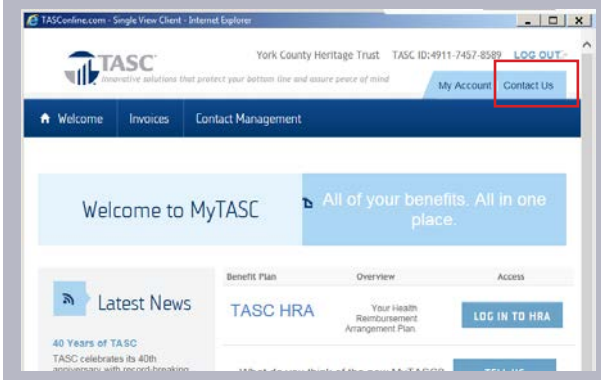
How to Submit a MyService Request

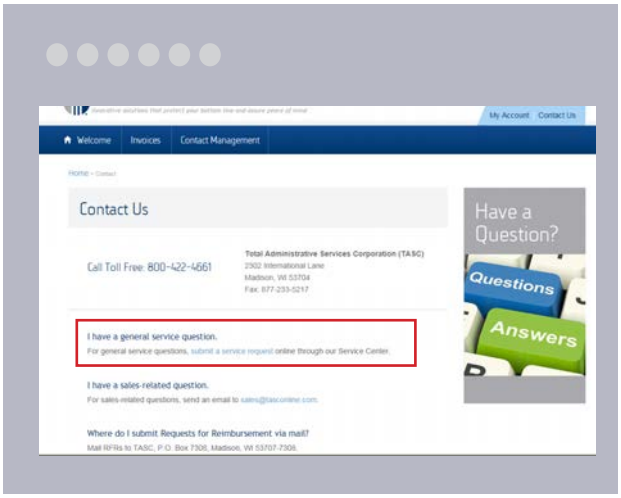
It's easy to communicate with TASC via our online Service Request option. Requests submitted via this secure online portal are processed within 24-48 hours and assigned a work order tracking number. See the instructions below to learn how to take advantage of this great TASC feature!

1. First log in to your account at www.tasconline.com using your username (or 12-digit TASC ID) and password. For assistance with login, please contact Customer Care. For speediest assistance, be ready with your TASC ID.



2. After you log in to your account, click Contact Us in the screen's upper right corner.



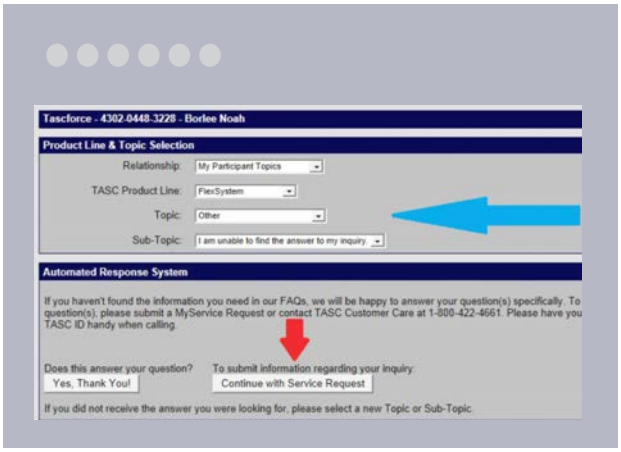


3. To submit a Service Request, click Service Request.

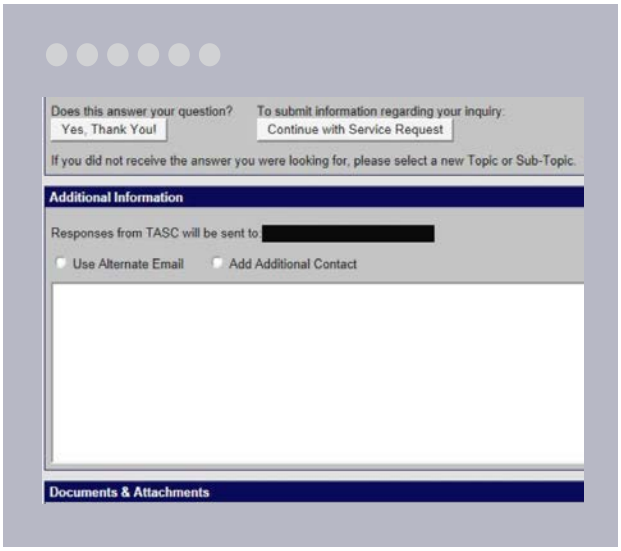
4. When you click Service Request, a window opens with drop down menus to guide you through our frequently asked questions. Select your relationship with TASC (Participant, Client, or Provider).

   Choose the product line for your account (FlexSystem, TASC HRA, COBRA, AgriPlan BizPlan, etc…).

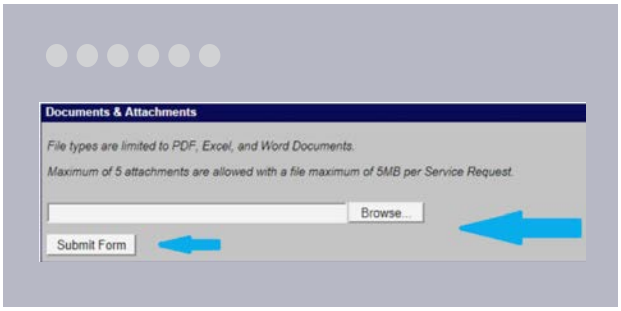
   To ask a question specific to your TASC account or submit documentation related to your account, choose "Other" as your topic and "I am unable to find the answer to my inquiry" as your sub-topic. Scroll down slightly and click Continue with Service Request.



5. If you have opted to Continue with the Service Request, a free form text box will appear in which you may type a custom message. Because you are logged in to MyTASC, your contact information will automatically upload with your request. If you require a specialized response (fax, mail, or telephone follow-up), please note your contact information in the request.



6. If you need to attach a document, select Browse. Navigate within your saved computer files and click Open to select the attachment file(s). The Service Request accepts up to 5MB of PDF, Microsoft Excel, and Microsoft Word file formats. Once you have selected all appropriate attachments, click Submit.



7. After submitting your request, take note of the Service Request number. This number is tracked in various TASC systems and can be used to follow up on your request.

   NOTE: If you do not receive an email confirmation immediately, check your Junk Email. To ensure that you receive important notifications such as this, please add donotreply@tasconline.com and tasconline.com to your list of contacts or approved senders.

8. If you have additional questions or concerns regarding the Service Request submission process, contact Customer Care.

Access Reports and Employee Accounts

Logging in to HRA Client Website

From the MyTASC homepage, select Log in to HRA, and then enter your HRA Client Website credentials. This will take you to the HRA administration pages.

Reporting

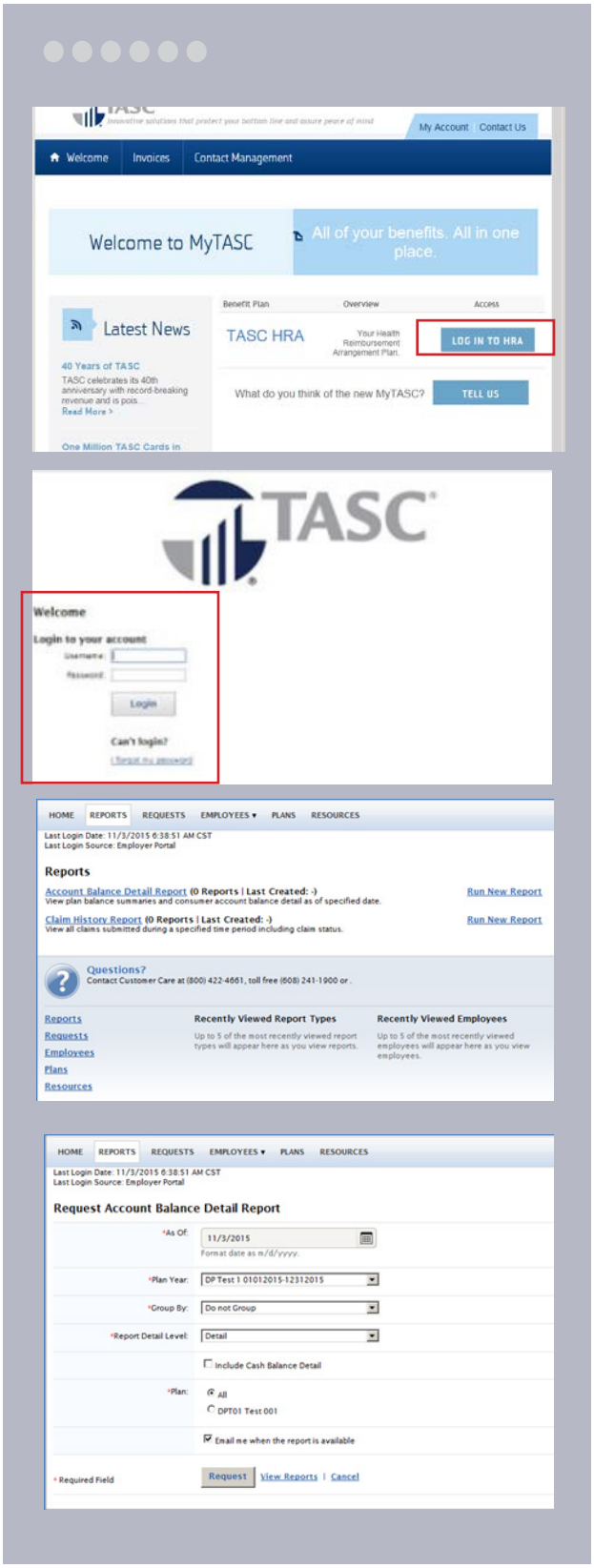
Your HRA homepage will show any recently created reports. To view the report, simply click on the name of the report.

You may also view reports by selecting the Reports tab. A list of your report history will be displayed on this page. Click on the name to view the report or generate a new report by clicking on Run New Report.

Account Balance Detail Report

The Account Balance Detail Report shows Plan balance information per Participant and per Plan.

1. To run the report, select the Date and Plan Year.
2. Select the Plan Year and report date.
3. Select Group By if you want to run the report by division.
4. Report Detail level allows you to show or remove Participant names.
5. Select Include Cash Balance Detail.
6. Plan: Select All to include all Plans or select an individual Plan.
7. Select Email me when the report is available.
8. Select Request
9. The report will show up on your Reports page for viewing.



Claim History Report

The Claim History Report will show all claims submitted during a specified date range including claim status.

1. To run the report, select the Plan Year, Start Date, and End Date.
2. Select Group By if you want to run the report by division.
3. Select Include Additional Information.
4. Plan: Select All to include all Plans or select an individual Plan
5. Select Email me when the report is available.
6. Select Request.
7. The report will show up on your Reports page for viewing.

Employee Accounts

To view employee account information, click on the Employees Tab. Search for the employee by entering the employee information in the quick search box or select View All Employees. You may limit your search by the employee status.

When viewing the employee list, click on the employee's last name to select the employee. This will take you to the employees Profile page. Click on any of the links at the top of the page to see specific Plan information for the employee.

Account Summary

The Account Summary shows the Participant's Plan summary information. Click on the account name to see the Participant's claims submitted.

Contributions

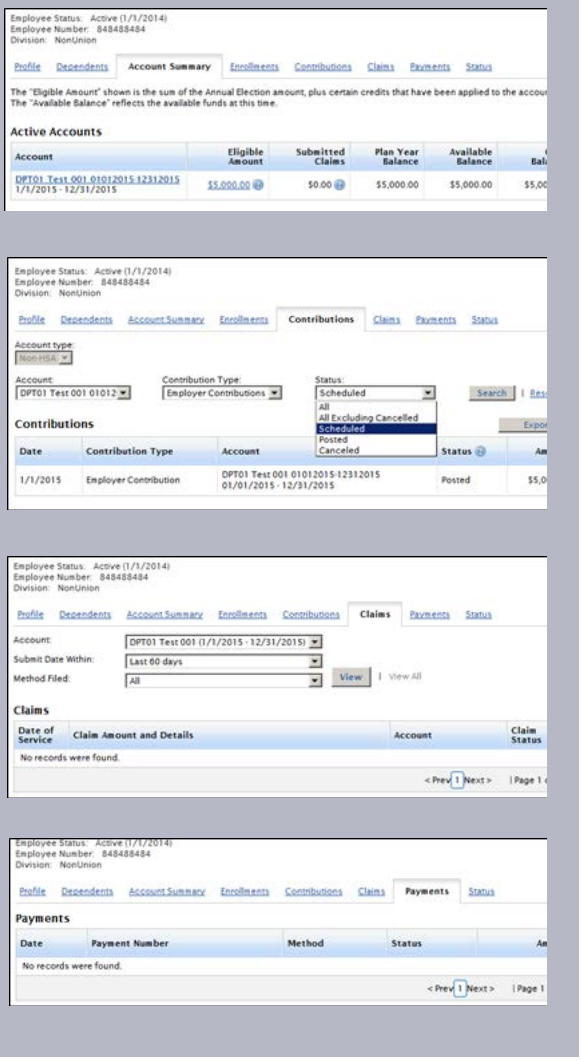
The Contributions view defaults to all. Choose the Account name, Contribution Type, and Status to view specific contributions.

Claims

Select an individual account, the submitted date range and/or method filed to view specific claims.

Payments

View a participant's paid claims and the status.



TASC Invoicing Practices

Purpose

TASC's Invoicing Practices aim to foster a clear understanding by communicating expectations to all Clients and Providers, ensuring compliance to TASC Plans and services, creating consistency between all of TASC's divisions, and ensuring the continuation of services.

Philosophy

To ensure that TASC operations continue to run smoothly, various actions need to occur in a timely manner, including the payment of TASC administrative fees. Paying in advance demonstrates that the Plan is for the benefit of employees, provides further evidence that the Plan has been established on a pre-thought basis, and ensures coverage under TASC's Audit Guarantees. TASC invoices in advance for two reasons:

1. TASC requires a commitment in advance of the business being processed, and
2. TASC requires a payment history for its Clients, so as to determine the Clients' status of good standing.

Administrative Fees

Because your TASC HRA service begins before the Plan start date, TASC invoices 45 days prior to the Plan start date. For example, for Plans with a January 1 start date, the first invoice is mailed on November 15 and is due seven days from the invoice date. TASC fees are calculated on the number of known Participants at the time the invoice is generated, and Clients are charged a minimum administrative fee.

Terminated Employees

A Participant is anyone who has elected to participate in a Client's Plan. A Participant remains a Participant in the Plan from the time of election through the date they terminate employment with the Client. Terminated Participants have until the end of the Plan runout to submit claims incurred prior to their termination date.

Types of Payments for Administrative Fees

Check

Clients may pay by check.

E-Pay

Clients may pay administrative fees electronically as long as they use E-Pay, and as long as these fees are debited 7 days prior to their service period start date. Therefore, if a service period begins January 1, Clients will be debited on December 23.

ACH Credit

Clients may pay administrative fees or funding invoices via an electronic ACH Credit transfer. A $40 per transaction service charge will be assessed. Clients should contact their Provider for details.

ACH Debit

Clients may pay administrative fees or funding invoices via an electronic ACH Debit transfer.

Types of Invoices

Administrative Fee
Generated annually, quarterly, or monthly for TASC services that are provided during a pre-determined service period.

Premium Services Fee
Generated when a Client has elected a Premium Service.

Standard Invoicing Procedures

Invoice
Generated and sent 45 days prior to the Service Period start.

Due Date
Will be seven days from the date the invoice was generated (invoice date).

Service Charge Date
An additional $20 fee will be assessed 60 days from the original invoice date if the invoice is not paid by the Service Charge due date, and the account will be placed on hold. Exception: If TASC HRA funding invoices are not paid within 21 days of Plan start a notice will be send to the Client; if the invoice remains unpaid at 30 days, the account will be placed on hold.

Statement
A Statement (second notice) of unpaid invoices will be mailed 15 days prior to the start of the Service Period.

Past Due Email Notification
On the first day of the Service Period or 45 days after the original invoice date (whichever comes first), an email will be sent to any account with unpaid invoices older than 40 days. This email will inform the Client that the account will be put on hold and that a $20 service fee will be charged if the invoice is not paid within 60 days of the original invoice issue date.

Final Notice Statement
A Final Notice Statement (third notice) will be mailed out 15 days into the Service Period, with a Service Charge of $20, a notice of "default" status, and a notice that all account services have been placed on hold.

Collections
The account will be placed in Collections 45 days into the Service Period start, or 90 days after the original invoice date, whichever comes first.

Plan Termination
The account will be terminated 104 days into the Service Period start. Letters will be sent to each Client being terminated.

Fee Calculations
Fees are calculated on the number of known Participants at the time the invoice is generated. Administrative fees are either the minimum fee or the number of Participants multiplied by the per Participant fee, whichever is higher. If the number of Participants is unknown, the minimum fee will be charged.

Client Responsibilities

1. Please make your checks payable to TASC Administration. Checks incorrectly made out to TASC can cause some confusion and may delay the administration of your Plan.

2. Mail invoices and payments in the envelope provided (goldenrod color) to: TASC Client Invoices, PO Box 88278, Milwaukee, WI 53288-0001.

    - All invoice payments must be submitted separately from all other payments and transactions.

    - All invoice payments must be made separately (i.e. one check with one invoice).

3. Notify TASC of any disputes or any changes.

4. Pay for all Participants through the runout period.

Business Processing Event Timeline

Event Kit		Event Title	Duration	Responsibility
	1.	Submit application with fees.	Varies*	Provider
	2.	TASC receives and previews application.	2+ days (if clean)	TASC
	3.	TASC enters the new business.	1+ days	TASC
Kit One	4.	Email Client materials including Client Administrative Manual, Enrollment Spreadsheet, and Participant Change Form.	1 day	TASC
	5.	TASC contacts Client via email to set up Welcome Call.	1 day	TASC
	6.	Welcome Call is scheduled and completed. (Note: TASC HRA Plan is NOT set up until Welcome Call is completed.)	Varies*	Client/TASC
	7.	Enrollment Meeting.	Varies•	Client
	8.	Complete and send enrollment spreadsheet to TASC.	Varies•	Client
	9.	Import Participant and dependent enrollment into the administration system.	Varies•	TASC
Kit Two	10.	Participant Reference Guide sent to Participants.	1 day	TASC and Post Office
	11.	Email to the Client the Summary Plan Description, Summary of Benefits and Coverage (if required), and the HIPAA Compliance Manual for distribution to Participants.	60 days from start date	TASC
Kit Three	12.	Email Client Plan Funding Arrangement letter.	1 day	TASC
	13.	TASC ACH Client funds established, based on the Fund Arrangement amount.	Varies•	TASC

**Varies = TASC is unable to determine the number of days in the cycle this event will require as the responsibility for this event is beyond TASC's control.*

PCORI Fees

The Patient-Centered Outcomes Research Institute (PCORI) was established by the Patient Protection & Affordable Care Act (PPACA) to evaluate the quality of various medicines and treatments. A private, non-profit corporation, this Institute conducts comparative clinical effectiveness research and is funded in part by plan sponsors (i.e., employers) of self-insured health plans.

Employers/plan sponsors with self-insured health plans (including non-excepted Health Reimbursement Arrangements and non-excepted Health Flexible Spending Arrangements) are required to file IRS Form 720 and remit PCORI fees to the Treasury Department on an annual basis. Fees are payable on a seven year rolling schedule for Plan Years beginning on or after October 1, 2012 through Plan Years ending September 30, 2019. Fees are due on July 31 of each year for Plan Years that ended during the prior calendar year. Initially this fee is $1 per each covered life; it will then increase to $2 after the first year and in subsequent years will be adjusted based on medical inflation rates.

TASC PCORI will handle all the bother and decipher the confusion inherent in meeting the new requirements. For a small fee, we will take the mystery out of PCORI and make sure your Plan is in compliance. We will unravel the complexities of employee count determination and fee calculation. We will send you complete instructions for completing and filing IRS Tax Form 720 along with the required PCORI information. By alleviating this confusion, TASC PCORI helps you maintain and continue this important employee benefit.

TASC's ERISAEdge has added the PCORI service to its service offering. At no charge to ERISAEdge Clients, TASC will, on an annual basis, assist in determining which of your Plans are subject to these fees and the actual fees due. In addition, ERISAEdge will provide you with guidance relating to the filing of IRS Form 720 and payment of the fees.

Technical and Customer Service Support

TASC has a team of employee benefit experts to assist you with your Plan. Clients and Participants may call toll-free (from 8 a.m. to 5 p.m.) to address questions regarding Plan compliance, election and enrollment procedures, account balances and technical issues, or other questions.

Phone: **1-800-422-4661**

Fax: **608-663-2754**

Web: **www.tasconline.com**

1. Log in to your online account at www.tasconline.com.
2. Click Contact Us in the upper right corner of the page.
3. Click Submit a MyService Request. This will open a new page with the email submission form.

Online requests are usually addressed within 24-48 business hours.

If your question is extremely time sensitive, please contact Customer Care for assistance. Our Customer Care Specialists are available to speak with you from 8 a.m. to 5 p.m. Monday through Friday, all time zones.

For Your Benefit

TASC also distributes For Your Benefit, a bi-annual newsletter that includes Plan updates and a calendar of important dates, along with information about other TASC Plans and guidance for managing and developing your business.


A NEWSLETTER FOR CLIENTS OF TASC'S GROUP SERVICES

[FOR YOUR] Benefit

TASC Offers Multiple Methods of Communication!

Inside this issue...

KEEP UP WITH THE LATEST TASC NEWS ON-LINE!

What is "Confidentially Speaking"

The Confidentially Speaking program guarantees that TASC employees, customers, and vendors can safely and anonymously communicate with management regarding sensitive information. We respect and value your opinions, and hope you will feel comfortable using this program to communicate serious problems or concerns.

Confidentially Speaking is administered by Navex Global, an independent organization that is contractually forbidden to disclose your personal information to TASC (unless you give them permission).

How does it work?

If you have knowledge about the occurrence of unethical activity, promptly report the situation to a Confidentially Speaking representative via our website at www.tasc.alertline.com or via phone at 877-874-8416.

Learn more! View the Confidentially Speaking Reporting Program flyer. (Download from www.tasconline.com/tasc-hra-documents.)

ACA Employer Reporting
COBRA Administration
DoxBox
ERISA Compliance
Flexible Spending Accounts (FSA)
FMLA Administration
Form 5500 Preparation
Funded HRA
GiveBack
Health Reimbursement Arrangements (HRA)
Health Savings Accounts (HSA)
HIPAA Compliance
Medicare Part D
Non-Discrimination Testing
PayPath Payroll Services
PCORI
Retiree Billing
Transit & Parking

Total Administrative Services, Inc.

2302 International Lane, Madison, WI 53704-3140
800-422-4661

www.tasconline.com

DP-3420-041818