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FLEXIBLE BENEFIT PLAN

Effective Date: 1/1/2022



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INTRODUCTION

Littelfuse, Inc. (the company) sponsors the Littelfuse, Inc. Flexible Benefit Plan (Flex Plan). The Flex Plan was established to combine various health and welfare benefits offered by the company in a single document. A current list of all benefit options under the Flex Plan is included under “Plan Names and Numbers.”

When used in this booklet (unless otherwise noted), the terms “you” and “your” mean a person who satisfies the eligibility requirements for the Flex Plan. The terms “we” and “us” refer to the company as plan administrator or plan sponsor of the Flex Plan.

Please carefully read the information in this summary, together with other documents that are designated as part of the SPD by the plan administrator so you will have a full understanding of your Flex Plan benefits.

As a summary plan description (SPD), this document cannot explain how every Flex Plan provision might apply in your particular situation. If you have any questions about the Flex Plan or how it applies to you, or if you would like to review or order your own copy of the legal Flex Plan documents, please contact the **Littelfuse Benefits Department** at UBenefits@Littelfuse.com or **773-628-1000**. Unless contrary to law, the Flex Plan documents will control in the event of a discrepancy between this SPD and the Flex Plan documents.

Your receipt of this SPD does not necessarily mean you are eligible for the Flex Plan or for all benefit options under the Flex Plan. You must satisfy the specific eligibility and participation requirements provided later in this SPD, the Flex Plan documents and the summaries for the applicable benefit options.

If this SPD has been delivered to you electronically, you have the right to receive a paper copy. You may request a paper copy at no charge by contacting the **Littelfuse Benefits Department at UBenefits@Littelfuse.com or **773-628-1000**.**

Important Information

This summary describes the “wrap” provisions of the Flex Plan. The benefit options under the Flex Plan are explained in vendor booklets, schedule of benefits, contracts, certificates, and/or coverage brochures which are used in conjunction with this SPD. This Flex Plan wrap summary along with the above documents for the benefit options provides a complete SPD for the Flex Plan.

The terms of the documents (including insurance contracts) that provide the terms and conditions of participation under each benefit option (themselves referred to as the summaries) are incorporated by reference. The inclusion of any voluntary insurance coverages, cafeteria plan provisions and/or flexible spending accounts in this SPD is intended solely for consolidation purposes and is not intended to indicate any such coverage is or is not subject to ERISA.

PLAN AT A GLANCE

Features	Provisions
Enrolling	<u>Voluntary Benefit Options:</u> The first day of the month on or after your date of hire, if you enroll within 31 days of your hire date. If you do not enroll within 31 days of your hire date or during an annual open enrollment period, the only way to enroll during the calendar year is if you have a qualified life event or special enrollment rights. <u>Employer-Provided Benefit Options:</u> The first day of the month on or after your date of hire for STD, LTD, basic life and AD&D; the date of hire for EAP and BTA.
Pre-Tax Contributions	Contributions you make to the following benefit options are done on a pre-tax basis (unless you are paid via a non-U.S. payroll of the company or to the extent you cover a civil union partner or his/her dependents): ■ Medical, including the prescription drug program ■ Dental ■ Vision ■ HealthCare Flexible Spending Account (HCFSAs) ■ Dependent Care Flexible Spending Account (DCFSAs) ■ Health Savings Account (HSA) That means your contributions are not subject to federal, Social Security and most state and local taxes. Keep in mind, your Social Security benefit may be slightly reduced because of these pre-tax contributions.
After-Tax Contributions	You pay the full cost through after-tax deductions from your compensation during the calendar year for the following benefit options. ■ Supplemental Life/AD&D ■ Group Legal Insurance ■ Identity Theft Protection ■ Any benefits covering civil union partners or their dependents
Company-Paid Coverage	The company pays the total cost for you and, if applicable, your eligible dependents for: ■ Employee Assistance Program (EAP) ■ Short-Term Disability (STD) ■ Long-Term Disability (LTD) ■ Basic Life and Accidental Death & Dismemberment (AD&D) insurance ■ Business Travel Accident (BTA) insurance

ELIGIBILITY

Important Information

Associates' eligibility to enroll themselves and their eligible dependents in each benefit option offered under the Flex Plan is governed by the terms of the contract for each benefit option, which is outlined below and in each benefit option's summary. Eligibility requirements are not the same for all benefit options, so be sure to review the applicable summary. The class of coverage for basic life and AD&D coverage as well as Short-Term Disability (STD) coverage are defined in the summaries.

ASSOCIATE ELIGIBILITY

You are eligible for coverage under the Flex Plan if you are actively employed on a full-time basis working a minimum of 30 hours per week. If you are a full-time associate and your regularly scheduled hours decrease to less than 30 hours per week so that you become a part-time associate, you will continue to be eligible for Benefit Options offered under the Flex Plan.

Certain individuals are specifically excluded from eligibility. For example, in general, seasonal associates are not eligible for coverage under the Flex Plan, nor are associates located outside the U.S., except for certain associates employed by Littelfuse Mexico Manufacturing B.V. – Mexico Branch. In addition, an associate is eligible only if the company classifies the associate as a common law employee and only for the period during which the company classifies the associate as a common law employee. An individual who is classified by the company as a non-common law employee (such as a contractor, consultant, advisor, director or leased employee) is ineligible for the Flex Plan, even if a court or administrative agency later determines that the person is a common law employee. An individual who is hired after January 1, 2018 and classified as an intern is ineligible for the Flex Plan.

DEPENDENT ELIGIBILITY

Your eligible dependents can also participate in any of the benefit options for which you elect coverage, i.e., those options that are not fully paid by the company, provided you enroll them in a timely manner. To be eligible for coverage, a dependent must have a valid social security number (this applies for all dependents other than newborns). Eligible dependents include:

- Your legal spouse or civil union partner
- Your children, or those of your spouse or civil union partner, who are under age 26 (or age 26 and older, if permanently and totally disabled and unable to support themselves financially)

When you enroll your dependents in benefit options offered under the Flex Plan, you acknowledge and represent that all your covered dependents meet the definition of eligible dependents based on the Flex Plan's and that particular benefit option's rules and definitions. The Flex Plan may require documentation of proof of dependent status and reserves the right to request additional documentation at any time, including as part of periodic audits or in connection with your enrollment or reenrollment of a dependent. Such required documentation may include birth and marriage certificates, and/or any other form of proof that the Flex Plan administrator deems appropriate or necessary.

You must notify the Littelfuse Benefits Department of any change in dependent status that might affect a dependent's eligibility for benefits within 31 days of the change (60 days if the change is due to a termination of Medicaid or CHIP coverage).

About Your Eligible Children

An eligible child is a child who is your:

- Natural child
- Stepchild
- Legally adopted child or child placed with you for adoption
- Children of your civil union partner
- Child for whom you have been ordered to cover through a Qualified Medical Child Support Order (QMCSO) or its equivalent (see Qualified Medical Child Support Order below)
- Child for whom you have legal guardianship



Qualified Medical Child Support Order

If we receive an order from a court or administrative agency directing the Flex Plan to cover your child under a medical, dental, vision or Health Care FSA (HCFSA) benefit option offered under the Flex Plan, the Flex Plan will enroll your child as provided in such order if we determine:

- The order is a Qualified Medical Child Support Order (QMCSO), and
- Your child would otherwise be an eligible dependent, as required by ERISA Section 609(a).

Coverage may continue for the period specified in the QMCSO up to the time the child ceases to satisfy the definition of an eligible dependent under the applicable benefit option. If you are required to pay a higher premium to cover the child (e.g., for Family Coverage), we may increase your payroll deductions under our cafeteria plan. During the period the child is covered under the Flex Plan as a result of a QMCSO, all plan provisions and limits remain in effect with respect to the child's coverage, except as otherwise required by federal law.

The Flex Plan has procedures for determining whether an order qualifies as a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting the **Littelfuse Benefits Department** at **UBenefits@Littelfuse.com** or **773-628-1000**.

You may cover your eligible dependent children up to age 26 in any of the benefit options for which you elect coverage, i.e., those options that are not fully paid by the company, even if they:

- Are employed and have coverage available,
- Are married,
- Are not full-time students,
- Do not permanently reside with you, or
- Are not tax dependents.

An eligible dependent child will be covered under this Flex Plan until the earlier of the:

- End of the month in which the dependent child turns 26 or fails to qualify as your dependent, or
- Last day of your participation in the Flex Plan.

Disabled Dependent Children

Eligible disabled dependent children over the age of 26 must be permanently and totally disabled and unable to support themselves financially. Extended coverage for disabled children is subject to periodic verification by the Claims Administrator.

Additionally, certain optional benefit options offered under this Flex Plan (Business Travel Accident coverage, legal services, ID theft protection services, and Dependent Care FSA) offer different, sometime more generous, coverage provisions for your dependents. See the summaries of those benefit options for more information.

If You and a Dependent Both Work at Littelfuse

If you and your spouse or civil union partner both work at Littelfuse, you cannot receive duplicate coverage in the Flex Plan. If you do not have children, you can elect Associate plus Spouse Coverage and your spouse or civil union partner can elect no coverage or vice versa. Or, you could both elect Associate Only Coverage. If you have children, you and your spouse or civil union partner cannot cover the same children as dependents.

If you have a dependent who also works for Littelfuse as a benefits-eligible associate, the dependent cannot receive duplicate coverage in the Flex Plan. You can cover your dependent if he or she meets the eligible dependent definition and your dependent can elect no coverage. Or, your dependent can elect Associate Only Coverage and you would not cover this dependent.

WHEN COVERAGE STARTS

If you are a new associate with Littelfuse enrolling during the year, coverage under the Flex Plan for you and your eligible dependents will begin on the first of the month on or after your hire date (except for EAP and BTA, which begin immediately), provided that for Short-Term Disability, Long-Term Disability and Business Travel Accident coverage, if you are absent from work due to injury, sickness, temporary layoff or leave of absence on the day your coverage would normally begin, your coverage will begin on the date you return to active employment.

Basic Life and AD&D and Voluntary Life and AD&D coverage for amounts subject to Evidence of Insurability (EOI) (as defined in the summary) begins on the date UNUM approves your evidence, provided that, if you are absent from work due to injury, sickness, temporary layoff or leave of absence on the day coverage would normally begin, your coverage will begin on the first day of the month on or after the date you return to active employment. If your eligible spouse or civil union partner is totally disabled, his or her Life and AD&D coverage will begin on the first of the month on or after the date he or she no longer is totally disabled.

Your initial election will run through December 31 of your first year in the Flex Plan unless you make a change based on a qualified life event or special enrollment event permitting a mid-year election change. If you do not make an election to enroll in voluntary benefit options as a new hire within 31 days of your hire date, you will not be able to elect coverage in such benefit options under the Flex Plan until the next annual open enrollment period, unless you have a qualified life event or special enrollment event.

If you enroll during the annual open enrollment period, coverage for you and your eligible dependents will begin on January 1 and remain in effect through December 31. If you do not make elections during annual open enrollment, you will not have any group health plan coverage starting on January 1 unless there is a communicated passive enrollment where your elections will roll-over to the next plan year.

PAYING FOR COVERAGE

You and Littelfuse share the cost of your medical and dental coverage. You pay the full cost of your vision coverage and any flexible spending account contributions you elect to make. Your portion of the cost of coverage for yourself, your spouse and your dependents is deducted from your paycheck on a pre-tax basis, that is, before federal — and, in most cases, state — income taxes and FICA taxes are withheld. If you have elected coverage for your civil union partner and/or his or her children, the cost for that coverage will be deducted on an after-tax basis, unless the individual qualifies as your federal tax dependent.

You also pay the full cost of any coverage for Supplemental Life and AD&D, Legal and Identity Theft Assistance coverage. The cost for these coverages is deducted from your paycheck on an after-tax basis.

Littelfuse pays the full cost for other benefits such as Short-Term Disability, Long-Term Disability, Basic Life and AD&D, the Employee Assistance Program and Business Travel Accident coverage.

MAKING CHANGES DURING THE YEAR

Because you pay for some of your Flex Plan coverage with pre-tax dollars, you can make changes during the year only if you have a change in your family or employment status (a qualified life event) or if you experience a special enrollment event permitting a mid-year election change. Approved qualified life events under the Flex Plan include:

- Birth, adoption of a child or placement for adoption
- Death of a child
- Death of a spouse
- Divorce/legal separation of a spouse
- Gain or lose legal custody of a child
- Marriage
- You gain eligibility for other coverage
- You lose eligibility for other coverage
- Spouse gains eligibility for other coverage
- Spouse loses eligibility for other coverage
- Child gains eligibility for other coverage
- Child loses eligibility for other coverage
- ZIP code change that affects carrier availability (such as a loss of HMO coverage)
- Spouse or dependent becomes eligible or ineligible for a benefit option

As long as you notify the Littelfuse Benefits Department within 31 days of the qualified life event, changes made during the year are generally effective on the date you make them, with some exceptions:

- If you are a new hire with Littelfuse, your benefit elections will be effective the first of the month on or after your hire date.
- Changes related to the birth, adoption or placement for adoption of a child will be effective on the date of birth, adoption or placement for adoption, as long as you make your elections within 31 days of the birth, adoption or placement for adoption date.

Any election change you make during the year as a result of one of the above events must be permitted by law and consistent with the event. Election changes are consistent with a qualified life event only if the election change is on account of and corresponds with an event that affects eligibility for either you, your spouse or your dependent under the Flex Plan or the group health plan of your spouse's or dependent's employer. **You must notify Littelfuse of the qualified life event within 31 days of the event.**

If you terminate employment and are rehired in the same calendar year (but more than 30 days after your termination date), you will be able to make new Flex Plan elections. If you are rehired within 30 days of your termination date, your most recent elections will be reinstated and effective immediately.

Other events permitting mid-year election changes include:

- **Changes consistent with the special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA):** See the [HIPAA Special Enrollment Rights for Medical Plan Coverage](#) section for further details.
- **Changes required by a judgment, decree or order, including a qualified medical child support order (QMCSO), resulting from a divorce, legal separation, annulment or change in legal custody that requires health care coverage for your child:** If the order directs you to cover the child and the child is an eligible dependent, you may enroll the child (and yourself) in the required coverage under the Flex Plan. If the order directs someone other than you (e.g., your spouse or former spouse) to cover the child, you may drop coverage under the applicable benefit option under the Flex Plan for the child, but only if the other coverage is actually provided. See the [About Your Eligible Children](#) section for further details.

- **Changes due to entitlement (or loss of entitlement) to Medicare or Medicaid:** If you, your spouse or a covered dependent becomes entitled to Medicare or Medicaid (i.e., becomes enrolled), you may drop or reduce medical coverage under the Flex Plan for that individual. If you, your spouse or a dependent loses entitlement to Medicare or Medicaid, you may enroll or increase medical coverage under the Flex Plan for that individual (and yourself).
- **Changes as may be required under the Family and Medical Leave Act (FMLA):** If you take leave under the FMLA, you may revoke your elections under the Flex Plan. When you return from FMLA leave, you may make elections for the remaining portion of the period of coverage as may be provided for under the FMLA. See the [Continuation of Coverage While on a Family and Medical Leave](#) section for further details.

Coverage changes:

- **Change in coverage under another employer plan:** You may make a prospective election change that is on account of and corresponds with a change made under another employer plan if either:
 - The other employer plan permits its participants to make an election change that would be permitted under applicable IRS mid-year election change regulations or
 - This Flex Plan permits you to make an election for a plan year that is different from the plan year under the other employer plan (i.e., different open enrollment period).
- **Loss of coverage under other group health coverage:** You may make a mid-year election change to add coverage under the Flex Plan for you, your spouse or dependent if you, your spouse or dependent loses coverage under any group health coverage sponsored by a governmental institution, including the following:
 - A state's children's health insurance program (CHIP),
 - A medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization,
 - A state health benefits risk pool, or
 - A foreign government group health plan.

Please note that, due to current limitations under the federal tax laws, you will generally not have the right to drop, add or modify coverage if one of the above events involves a civil union partner or the child of a civil union partner (unless they qualify as your tax dependent). Please contact the [Littelfuse Benefits Department](#) at UBenefits@Littelfuse.com or [773-628-1000](tel:773-628-1000) to find out more.

Late Applicants

If you do not apply for the mid-year coverage change within the required number of days of the event, you will have to wait until the next open enrollment period (or another qualifying event) to make any changes.

Limited FSA Carryovers

Effective for plan years 2021 and 2022 only, the Health FSA Plan and Dependent Care FSA Plan allow the following limited carry overs:

If you had any unused 2020 contributions in your Health FSA or Dependent Care FSA account at the end of plan year 2020, those unused contributions could be carried over and used to reimburse eligible expenses incurred during plan year 2021 (**NOTE:** This limited carryover did not extend beyond December 31, 2021. You could not carry over unused contributions from 2020 into 2022. If you carried over 2020 contributions into 2021, those contributions were required to be used to reimburse eligible expenses by December 31, 2021 or they were forfeited).

If you had any unused 2021 contributions in your Health FSA or Dependent Care FSA account at the end of plan year 2021, those unused contributions could be carried over and used to reimburse eligible expenses incurred during plan year 2022 (NOTE: This limited carryover does not extend beyond December 31, 2022. If you carried over any 2021 contributions into 2022, those contributions must be used to reimburse eligible expenses by December 31, 2022 or they will be forfeited).

HIPAA SPECIAL ENROLLMENT RIGHTS FOR GROUP HEALTH PLAN COVERAGE (MEDICAL, DENTAL AND VISION)

Loss of Eligibility for Other Health Coverage

If you are declining enrollment for yourself or your dependents (including your spouse) for health care because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a health benefit option, or switch health benefit options under this Flex Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other non-COBRA coverage). However, you must request enrollment within 31 days after the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Loss of eligibility for coverage includes:

- Loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, or reduction in the number of work hours of employment,
- A situation in which a plan no longer offers any benefits to the class of similarly-situated individuals that includes the individual, and
- In the case of an individual who has COBRA continuation coverage, at the time the COBRA continuation coverage is exhausted.

However, loss of eligibility for other coverage **does not include** a loss of coverage due to:

- The failure of the employee or dependent to pay premiums on a timely basis,
- Voluntary disenrollment from a plan, or
- Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

When coverage begins: If you enroll yourself, your spouse and/or your eligible dependents in medical, dental or vision coverage under this Flex Plan due to a loss of eligibility for coverage event described above, that new coverage will begin the date the election is made in the enrollment system.

Gaining a New Dependent

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in medical, dental, or vision benefit options or switch medical, dental, or vision coverage options.

However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you are not already enrolled in a medical, dental, or vision benefit option as an associate, you must enroll in the same coverage when you enroll any of these dependents. And, if your spouse is not enrolled in the same coverage, you may enroll him or her and any other eligible dependents when you enroll a dependent due to birth, adoption or placement for adoption.

When coverage begins: In the case of birth, adoption, or placement for adoption, coverage is retroactive to the date of birth, adoption, or placement for adoption, as applicable, provided that your request for enrollment is made within 31 days after the birth, adoption, or placement for adoption.

In the case of marriage, coverage begins on the date the election is made in the enrollment system.

Please note that, due to current limitations under the federal tax laws, you will generally not have special enrollment rights if one of the above events involves a civil union partner or the child of a civil union partner (unless they qualify as your tax dependent). Please contact the **Littelfuse Benefits Department** at UBenefits@Littelfuse.com or **773-628-1000** to find out more.

LOSS OR GAIN OF ELIGIBILITY FOR A STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OR MEDICAID

If you are eligible for, but not enrolled in, a medical, dental, or vision benefit option (or your dependent is eligible for, but not enrolled in, such coverage), you (and your dependent) may enroll in a medical, dental or vision benefit option if **either** of the following conditions is met:

- You (or your dependent) are covered under CHIP or Medicaid and such coverage is terminated as a result of loss of eligibility, and you request coverage under a benefit option not later than 60 days after the date of termination of such CHIP or Medicaid coverage, or
- You (or your dependent) become eligible for CHIP or Medicaid premium assistance subsidy with respect to coverage under a benefit option, if you request coverage under the Flex Plan not later than 60 days after the date you or your dependent is determined to be eligible for such premium assistance subsidy.

(CHIP benefits are different in each state and may or may not cover dental and vision. To determine if your state's CHIP benefit extends to dental or vision, please consult the Flex Plan's annual CHIP notice, which is provided to you as part of open enrollment materials or can be obtained by contacting the Littelfuse Benefits Department.)

When coverage begins: If you enroll yourself, your spouse and/or your eligible dependents due to a loss or gain of eligibility for a coverage event described above, coverage under this Flex Plan will begin on the date the election is made in the enrollment system.

Premium Assistance: If you or your dependents who are eligible for Medicaid or CHIP and also eligible for health coverage under the Flex Plan, your state may have a premium assistance program that can help pay for coverage, using funds from the state's Medicaid or CHIP Programs. Details regarding state premium assistance programs are provided to you in the Flex Plan's annual CHIP notice, which is provided to you as part of open enrollment materials or can be obtained by contacting the Littelfuse Benefits Department.

Please note that, due to current limitations under the federal tax laws, you will generally not have CHIP-related rights if one of the above events involves a civil union partner or the child of a civil union partner (unless they qualify as your tax dependent). Please contact the **Littelfuse Benefits Department** to find out more.

To request special enrollment or obtain more information, contact the **Littelfuse Benefits Department** at UBenefits@Littelfuse.com or **773-628-1000**.

WHEN COVERAGE ENDS

In general, depending on the benefit options in which you are enrolled under this Flex Plan, coverage will either end on the date your employment with Littelfuse ends or the last day of the month in which your employment with Littelfuse ends (consult the benefit option's summary for the specific rule that applies). Coverage may also end for other reasons, such as:

- Littelfuse terminates the Flex Plan
- You are no longer eligible for the benefit option
- You fail to make any required contributions
- You are on layoff or LTD leave of absence beyond the end of the month following the month in which the layoff or leave began
- You die
- You elect not to participate in the benefit option, or the Flex Plan, for the plan year
- You fail to reimburse the Flex Plan for any claims paid, for which, under the terms of the Flex Plan, you are required to reimburse the Flex Plan
- You fail to comply with the terms and conditions of the benefit option summary or the Flex Plan
- You provide false or misleading information to the Flex Plan

A covered dependent will cease to participate in a benefit option or the Flex Plan on an earlier date if the dependent is no longer eligible to participate in or withdraws from the benefit option or the Flex Plan. Unless specifically mentioned in a benefit option summary, if a dependent becomes ineligible, his or her coverage will end on the last day of the month in which the event occurs that makes him or her ineligible.

You may be able to continue your medical, dental, vision, or HCFSAs coverage under the Flex Plan through the Consolidated Omnibus Budget Reconciliation Act (COBRA) (see the **Continuation Coverage Rights under COBRA** section). You may also be able to continue certain benefit option coverages if you are on military leave (see the **Continuation of Coverage for Employees in the Uniformed Services** section) or if you are on an approved Family and Medical Leave Act (FMLA) leave (see the **Continuation of Coverage While on a Family and Medical Leave** section).



Change in Employment Status

If you are no longer eligible to participate in the Flex Plan because of a change in employment status or classification (other than through termination of employment), you will become a limited participant in this Flex Plan for the remainder of the calendar year in which such change of employment status occurs. As a limited participant, no further salary reduction may be made on your behalf, and all further elections will cease, except to the extent that pre-tax salary reductions are permitted under the Code for continuation of medical, dental, vision, or HCFSAs coverage pursuant to COBRA.

If you cease to be an eligible associate for any reason (other than for termination of employment), including, but not limited to, a reduction of hours, and then become an eligible associate again, you must re-satisfy any eligibility requirements for the benefit options offered under the Flex Plan, including any employment waiting period, to rejoin the benefit option.



CONTINUATION OF YOUR COVERAGE

You may be able to continue coverage under the benefit options offered under this Flex Plan under certain conditions. Limited continuation rights may also be available with a HealthCare FSA.

CONTINUATION OF COVERAGE WHILE ON A FAMILY AND MEDICAL LEAVE

Under the federal Family and Medical Leave Act (FMLA), associates are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected coverage during this time. Littelfuse is required to allow medical, dental, vision, and HCFSAs benefit coverage to be continued by associates on FMLA leave whenever such coverage was provided before the leave was taken, on the same terms as if you had continued to work. If you receive pay during your FMLA leave, contributions will be deducted from your pay. Otherwise, your share of the cost of benefit options under this Flex Plan will continue to accrue during your FMLA leave as described in **Contributions** below.

You may take up to 12 weeks of unpaid leave under FMLA in a 12-month period. To report a FMLA leave contact UNUM at **1-866-779-1054**.

When You Can Take FMLA Leave

Eligible associates can take FMLA leave for the following reasons:

- For the birth and care of your newborn child or a child who is placed with you for adoption or foster care
- For the care of a spouse, child or parent who has a serious health condition
- For your own serious health condition
- For “any qualifying exigency” (a qualifying urgent situation or pressing need) arising out of the fact that the spouse, son, daughter or parent of the associate is on active duty or called to active duty status as a member of the National Guard or Reserves in support of a contingency operation.

Depending on the state you live in, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

Military Caregiver Leave under FMLA

An eligible associate who is the spouse, son, daughter, parent or next of kin (that is, nearest blood relative) of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member. This 26 weeks leave entitlement is reduced by any other type of FMLA leave taken during the same period. See U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, for Fact Sheets #28 and #28A, which provide further details on FMLA:

https://www.dol.gov/whd/fmla/fact_sheets.htm.

Contributions

Deductions for benefits will accrue and be deducted from your pay upon your return to work. If you don't return to work within the time frames outlined above, your coverage under the Flex Plan and its benefit options will end except to the extent you continue your medical, dental, vision, or HCFSAs coverage under COBRA. Additionally, under certain circumstances, you may still owe the company for both your deductions that have accrued as well as the company's share of the premiums that were paid on your behalf while the company expected you to return to work.

Returning from Leave

If you decline coverage during your FMLA leave or if your coverage is ended as a result of your failure to pay any required contributions, you will, on return from the FMLA leave, be automatically reinstated to the

Flex Plan on the same terms of coverage as before taking leave, without any waiting period or physical exam, but subject to the Flex Plan's eligibility rules, unless you elect otherwise.

If you take a FMLA leave and do **not** return to work at the end of your leave, you and your covered eligible dependents may elect COBRA coverage, if you and your dependents:

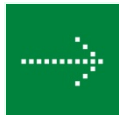
- Were covered under medical, dental, vision, or HCFSa coverage under the Flex Plan on the day before your leave began (or became covered during the leave); and
- Will lose medical, dental, vision, or HCFSa coverage because of your failure to return to work at the end of the leave.

COBRA coverage elected in these circumstances will begin on the first of the month following the cancellation of active coverage, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of employment termination and reduction of hours.

CONTINUATION OF COVERAGE FOR ASSOCIATES IN THE UNIFORMED SERVICES

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible associates who enter military service. The terms "Uniformed Services" or "Military Service" mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.



Please Note

Under USERRA, the maximum period of USERRA continuation coverage available to you and your eligible dependents is the lesser of 24 months after the leave begins or the day the leave ends. When you go on USERRA military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

Military Leave of 30 Days or Less

Coverage for associates on USERRA military leave and their dependents who are covered under the Flex Plan will remain in effect for the duration of any USERRA leave of 30 days or less. The associate will continue to pay the associate portion of the premium from his or her regular pay. If the associate elects not to continue to pay the premium during paid USERRA leave, coverage terminates 30 days after the effective date of the leave of absence.

If the associate has any period of unpaid USERRA leave, the premiums will go into arrears and will be deducted from the first paycheck received upon return to work.

Military Leave of More Than 30 Days

Coverage for associates on USERRA military leave and their dependents who are covered under the Flex Plan may continue for up to 24 months. The associate is required to continue to pay the associate portion of the premium from his or her regular pay while receiving differential pay (applies to emergency call-ups only) and such premium payments will be automatically withheld from the differential pay. In the case of unpaid leave, arrangements may be made to continue coverage through prepayments of the associate portion of the premium. If the associate elects not to continue to pay the premium, coverage terminates 30 days after the effective date of the leave of absence.

Upon return from USERRA leave, coverage will be reinstated without a waiting period.

For all inquiries relating to military leave, please contact UNUM at **1-866-779-1054**.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your period of duty, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your most recent period of uniformed service was from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your most recent period of uniformed service was more than 180 days.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the medical, dental, vision, Employee Assistance Program (EAP), and Health Care FSA benefit options under this Flex Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your covered dependents, and what you need to do to protect the right to receive it.** Refer to the section **Continuing Your HealthCare Flexible Spending Account under COBRA** for the special rules that apply to continuing participation in those accounts under COBRA.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under a group health plan because of a qualifying event. It can also become available to your spouse and dependent children who are covered under a plan when they would otherwise lose such coverage because of a qualifying event. The Flex Plan provides no greater COBRA rights than what COBRA requires. Nothing in this section is intended to expand your rights beyond COBRA's requirements.

Under current federal laws, your civil union partner and his or her dependent children do not have an independent right to elect COBRA continuation coverage unless they qualify as your legal tax dependent under the requirements established by the IRS. Instead, your civil union partner and his/her eligible dependents will only have rights to COBRA if you elect COBRA continuation coverage due to a "qualifying event" that affects you and that coverage happens to also cover your civil union partner and his/her eligible dependents.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan (medical, dental, vision, EAP and Health Care FSA) coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event." COBRA qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if covered under a group health plan benefit option under this Flex Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Additionally, a dependent who is born to or adopted or placed for adoption with you (the covered associate) during the COBRA continuation coverage period is also considered a qualified

beneficiary. Qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the [Paying for COBRA Continuation Coverage](#) section.

COBRA Qualifying Events

If you are an **associate**, you will become a qualified beneficiary if you lose coverage under a group health plan benefit option under this Flex Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the **spouse of an associate**, you will become a qualified beneficiary if you lose coverage under a group health plan benefit option under this Flex Plan because any of the following qualifying events happens:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his or her gross misconduct
- You become divorced or legally separated from your spouse

Your **dependent children** will become qualified beneficiaries if they lose coverage under a group health plan benefit option under this Flex Plan because any of the following qualifying events happens:

- The parent-associate dies
- The parent-employee's hours of employment are reduced
- The parent-associate's employment ends for any reason other than his or her gross misconduct
- The parents become divorced or legally separated
- The child stops being eligible for coverage as a "dependent child"

For this purpose, "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event (as described in COBRA).

Giving Notice of a COBRA Qualifying Event or Second Qualifying Event

The Flex Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Littelfuse Benefits Department has been timely notified that a qualifying event has occurred. When the qualifying event is the associate's termination of employment (other than for gross misconduct) or reduction of work hours, or death of the associate, the Littelfuse Benefits Department will take the necessary action to notify the COBRA administrator of the qualifying event.

Important Note: For the other qualifying events (divorce or legal separation of the associate and spouse or a dependent losing eligibility for coverage as a dependent), you (the associate) or the spouse or dependent must notify the Littelfuse Benefits Department within 60 days after the later of:

- The date of qualifying event (or second qualifying event), or
- The date the qualified beneficiary loses (or would lose) coverage under a group health plan benefit option under this Flex Plan as a result of the qualifying event (or second qualifying event).

This notice must be provided by calling the [Littelfuse Benefits Department](#) at UBenefits@Littelfuse.com or [773-628-1000](tel:773-628-1000) or sending written notice to:

Littelfuse Inc. Benefits Department
8755 West Higgins Road, Suite 500
Chicago, IL 60631

How COBRA Continuation Coverage Is Provided

Once the Littelfuse Benefits Department receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a "COBRA Continuation Coverage Election Notice") to qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered associates may elect COBRA continuation coverage on behalf of their spouses or dependents, and parents may elect COBRA continuation coverage on behalf of their children.

If coverage under a group health plan benefit option under this Flex Plan is changed for active associates, the same changes will be provided to similarly-situated individuals receiving COBRA continuation coverage. Qualified beneficiaries also may change their coverage elections during the annual open enrollment periods, and if certain qualified life events occur in a manner similar to active associates.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of group health coverage. When the qualifying event is the associate's termination of employment (other than for gross misconduct) or reduction of work hours, COBRA continuation coverage for the associate and the associate's covered spouse and dependents generally lasts for up to a total of 18 months from the date of the qualifying event or loss of coverage, whichever is later. For information on the different rules that apply to continuation of Health Care FSA participation, refer to the section [Continuing Your HealthCare Flexible Spending Account under COBRA](#).

When the qualifying event is the death of the associate, or your divorce or legal separation, COBRA continuation coverage for the associate's spouse and/or dependent children (but not the associate) lasts for up to a total of 36 months from the date of the qualifying event or loss of coverage, whichever is later. Also, the associate's dependents are entitled to COBRA continuation coverage for up to 36 months after losing eligibility as a dependent.

There are three ways in which the 18-month period of COBRA continuation coverage due to the associate's termination of employment can be extended.

- **Associate's Medicare Entitlement Occurs Before a Qualifying Event That Is Associate's Termination of Employment or Reduction of Work Hours:** When the qualifying event is the associate's termination of employment (other than for gross misconduct) or reduction of work hours, and the associate became entitled to (i.e., enrolled in) Medicare benefits less than 18 months before the qualifying event (even if Medicare entitlement was not a qualifying event for the associate's spouse or dependents because their coverage was not lost), COBRA continuation coverage for qualified beneficiaries other than the associate lasts until 36 months after the date of the associate's Medicare entitlement. For example, if the associate becomes entitled to Medicare eight months before the date on which employment terminates and coverage is lost, COBRA continuation coverage for the associate's covered spouse and dependents can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).
- **Disability Extension:** If you, your spouse or any of your dependents covered under group health coverage are determined by the Social Security Administration (SSA) to be disabled on the date of the associate's termination of employment or reduction of work hours, or at any time during the first 60 days of COBRA continuation coverage due to such qualifying event, each qualified beneficiary (whether or not disabled) may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for this disability extension, you must provide written notice to the Littelfuse COBRA Administrator regarding the person's disability status at **both of the following times:**
 - Within 60 days after the latest of:
 - The date of the disability determination by the SSA,
 - The date on which the qualifying event occurs,
 - The date on which you lose (or would lose) coverage under the group health coverage, or

- The date on which you are informed of both the responsibility to provide this notice and the Flex Plan's procedures for providing such notice to **the Littelfuse COBRA Administrator, AND**
- Before the original 18-month COBRA continuation coverage period ends. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you or the qualified beneficiary are required to notify **the Littelfuse COBRA Administrator** in writing within 30 days after this determination. Any notice of disability that you provide must include:
 - The name and address of the disabled qualified beneficiary,
 - The date that the qualified beneficiary became disabled,
 - The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage,
 - The date that the Social Security Administration made its determination,
 - A copy of the Social Security Administration's determination, and
 - A statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Send your written notice to the COBRA Administrator at:

**PayFlex Systems USA Inc.
P.O. Box 3039
Omaha, NE 68103-3039**

If these procedures are not followed or if the notice is not provided in writing to the **Littelfuse COBRA Administrator** within the required period, the qualified beneficiary will not receive a disability extension of COBRA continuation coverage.

Second Qualifying Event Extension: If the associate's spouse and/or dependent experience a second qualifying event while receiving the initial 18 months of COBRA continuation coverage, the associate's spouse and dependent (but not the associate) can get up to 18 additional months of COBRA continuation coverage, for a maximum of **36 months**, if timely notice of the second qualifying event is given to the COBRA Administrator. This extension may be available to the associate's spouse and any dependents receiving COBRA continuation coverage if the associate or former associate dies, or gets divorced or legally separated, or if the dependents stop being eligible under the Flex Plan as a dependent, but only if the event would have caused the spouse or dependent to lose coverage for group health coverage under the Flex Plan had the first qualifying event not occurred. If a second qualifying event occurs at any time during the 29-month disability continuation period (as described above), then each qualified beneficiary who is the associate's spouse or dependent (whether or not disabled) may further extend COBRA continuation coverage for seven more months, for a total of up to 36 months from the associate's termination of employment or reduction of work hours (or the date coverage is lost, if later). See the **Giving Notice of COBRA Qualifying Event or Second Qualifying Event** section for important details on the proper procedures and timeframes for giving this notice to the COBRA Administrator at: **PayFlex Systems USA Inc., P.O. Box 3039, Omaha, NE 68103-3039**. **If these procedures are not followed or if the notice is not provided in writing within the required 60-day period, the qualified beneficiary will not receive an extension of COBRA continuation coverage due to a second qualifying event.**

The table below provides a summary of the COBRA provisions outlined in this section.

Qualifying Events That Result in Loss of Coverage	Maximum Continuation Period		
	Associate	Spouse	Child
Associate's reduction of work hours (e.g., full-time to part-time)	18 months	18 months	18 months
Associate's termination of employment for any reason (other than gross misconduct)	18 months	18 months	18 months

Qualifying Events That Result in Loss of Coverage	Maximum Continuation Period		
	Associate	Spouse	Child
Associate or associate's covered spouse or dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event, or becomes disabled within the first 60 days of COBRA continuation coverage that begins as a result of termination of employment or reduction of work hours	29 months	29 months	29 months
Associate dies	NA	36 months	36 months
Associate and spouse legally separate or divorce	NA	36 months	36 months
Associate becomes entitled to Medicare within 18 months before termination of employment or reduction in work hours (even if such Medicare entitlement was not a qualifying event for the covered spouse or dependent because their coverage was not lost)	NA	36 months*	36 months*
Child no longer qualifies as a dependent child under the terms of the benefit plan option	NA	NA	36 months

* 36-month period is counted from the date the associate becomes entitled to Medicare.

Electing COBRA Continuation Coverage

You and/or your covered spouse and dependents must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered spouse and dependents would lose coverage under the group health coverage under the Flex Plan as a result of the qualifying event, or
- The date **the Littelfuse COBRA Administrator** notifies you and/or your covered spouse and dependents (through a "COBRA Continuation Coverage Election Notice") of the right to choose to continue coverage as a result of the qualifying event.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the active employee premium cost for the group health coverage (including both employer and associate contributions).

Premium Due Dates: If you elect COBRA continuation coverage for a group health benefit option, you must make your initial payment for continuation coverage (including all premiums due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Form is postmarked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under that benefit option. Payment is considered made on the date it is sent to the COBRA Administrator (the postmark date, or the date entered on the check if the postmark is unreadable).

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The premium due date and exact amount due for each coverage period will be shown on the COBRA payment coupons you receive. Although periodic payments are due on the dates shown on the COBRA payment coupons, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you elect COBRA continuation coverage for a group benefit option, but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period, respectively, for that coverage period, you will lose all rights to COBRA continuation coverage under that benefit option, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any person will end when the first of the following occurs:

- The applicable 18-, 29- or 36-month COBRA continuation coverage period ends
- Any required premium is not paid on time
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as an associate or otherwise) under another group health plan of the same type
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (i.e., enrolled in) Medicare benefits (under Part A, Part B or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare
- In the case of extended COBRA continuation coverage due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA continuation coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months
- For newborns and children adopted by or placed for adoption with you (the associate) during your COBRA continuation coverage, the date your COBRA continuation coverage period ends is also the date their coverage ends unless a second qualifying event has occurred
- Littelfuse ceases to provide that benefit option or another group health benefit option of the same type for its associates.

COBRA continuation coverage may also be terminated for any reason where the Flex Plan could terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Continuing Your HealthCare Flexible Spending Account under COBRA

Generally, if the benefit still available to you from a HealthCare Flexible Spending Account (FSA) as of the date of a qualifying event is greater than the COBRA premium for the rest of the plan year, you may continue your participation in the Health Care FSA under COBRA. Continuing contributions will be made on an after-tax basis for the remainder of the plan year in which a qualifying event occurs.

You will not be able to continue your participation in a Health Care FSA under COBRA if, for the plan year in which the qualifying event occurs, the COBRA premium for the rest of the plan year is greater than the benefit still available to you under a Health Care FSA as of the date of the qualifying event.

In no event will you be able to elect Health Care FSA participation for the plan year following the year in which the qualifying event occurs, even if your COBRA continuation period is still in effect for your medical, dental, vision, and/or EAP coverage.

You will be required to follow all of the notice, election, payment and termination provisions applicable to the medical, dental, vision, and EAP benefit options above.

If You Have Questions

Questions concerning the Flex Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your rights, as well as the rights of your spouse, civil union partner and dependents, you should keep **the Littelfuse COBRA Administrator** informed of any changes in the addresses of your spouse, civil union partner or dependents. You should also keep a copy for your records of any notices you send to **the Littelfuse COBRA Administrator**.

Plan Contact Information

For more information on your continuation rights under COBRA, please contact the COBRA Administrator at:

PayFlex Systems USA Inc.
P.O. Box 3039
Omaha, NE 68103-3039
1-800-284-4885

RESCISSION

In general, Littelfuse reserves the right to rescind (i.e., retroactively cancel or terminate) any coverage under the Flex Plan to the full extent permitted by law. For example:

- Your (and/or your dependent's) coverage may be terminated retroactively for failure to pay the required premiums or contributions on a timely basis.
- In general, coverage ends when an individual ceases to be eligible for coverage. If the loss of eligibility is determined only after the fact because of your delay in informing the Flex Plan administrator or a delay in administrative record keeping, the Flex Plan administrator reserves the right to terminate coverage for any individual retroactively to the date of loss of eligibility.
- Your (and/or your dependent's) coverage under the Flex Plan may also be terminated retroactively if you (and/or your dependent) perform an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact to the Flex Plan or to one or more of the insurers for our benefit options. For example, if the Flex Plan administrator determines that you have enrolled an individual who does not meet the Flex Plan's eligibility requirements as stated in this SPD or as stated in the enrollment materials, your enrollment of such ineligible individual(s) will be treated as an intentional misrepresentation of a material fact, or fraud, and the Flex Plan administrator reserves the right to retroactively terminate your (and/or your dependent's) coverage in the Flex Plan and all benefit options.



REQUIRED NOTICES

HIPAA PRIVACY RULES AND SECURITY STANDARDS

This Flex Plan is intended to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). Employers are required to provide notice of the ways that protected health information (PHI) may be used in accordance with HIPAA. You may request a copy of this notice by contacting the **Littelfuse Benefits Department** at **UBenefits@Littelfuse.com** or **773-628-1000**.

HEALTHCARE REFORM NOTICES

To comply with the Patient Protection and Affordable Care Act, as amended (known as Healthcare Reform or the ACA), the following rights and benefits are included in the Flex Plan:

- **Adult Children Are Covered Until Age 26.** You can cover your adult children (regardless of financial dependency, student status or residence) under medical and dental coverage until the end of the month in which the child reaches age 26. You are also eligible for reimbursement from your HCFSAs for eligible medical expenses incurred by these adult children.
- **No Exclusion of Pre-Existing Conditions.** No exclusions of pre-existing conditions of any individual will apply under medical coverage.
- **No Lifetime or Annual Limit.** No lifetime or annual limit applies to medical coverage.
- **Primary Care Provider Designations.** To the extent that any medical coverage requires or allows for the designation of primary care providers by participants or beneficiaries, you have the right to designate any primary care provider who participates in-network and who is available to accept you or your dependents; and to the extent that any benefit option that provides medical coverage requires or allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider for the child.
- **OB/GYN Designations.** To the extent that any medical coverage provides coverage for obstetric or gynecological care and requires the designation by a participant or beneficiary of a primary care provider, you do not need prior authorization from the network provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in-network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.
- **No Copay for Preventive Services and Wellness Care.** You are not required to pay a copayment or other cost-sharing under medical or dental coverage for preventive services and wellness benefits (as defined in the law), such as routine exams, immunizations, mammograms and routine baby care. Please see the schedule of benefits in the applicable benefit option's summary for more information.
- **Emergency Services.** You may seek emergency medical services at an in-network or out-of-network provider under medical coverage without having to obtain prior authorization. Any out-of-network emergency medical services are subject to the same copayments and deductibles as in-network emergency services, and the out-of-network provider will be paid at the same level as an in-network provider for the same service. Note, however, an out-of-network provider may balance bill you for the difference between its charge for the emergency services and the amount paid by the Flex Plan. Please see the applicable benefit option's summary for more information.

- **Newborns' and Mothers' Health Protection Act of 1996.** Medical coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Flex Plan or the insurance company for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).
- **Women's Health and Cancer Rights Act of 1998.** If your medical coverage includes coverage for mastectomy-related services, then you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical coverage. To obtain information on the deductibles and coinsurance that apply, refer to the respective summary for the benefit option that provides medical coverage contact the insurer of the benefit option. If the benefit option is provided through the general assets of the company or if you would like more information on WHCRA benefits, contact the **Littelfuse Benefits Department** at UBenefits@Littelfuse.com or **773-628-1000**.
- **Cash-Out Provision.** If you are an eligible associate, you may elect to receive cash in lieu of electing medical coverage under this Flex Plan. Any cash received by you under this provision will be limited to \$1,500 for each calendar year, payable with the first payroll cycle in each quarter in the amount of \$375 and subject to applicable federal and state tax withholdings. Former associates are not eligible for this cash-out provision.

CLAIMS

This section applies to all claims for benefits under the benefit options offered under this Flex Plan, except EAP or legal and ID theft protection services claims, and claims for eligibility to participate in this Flex Plan.

Entitlement to benefits under this Flex Plan is determined by the provisions of all documents forming part of this Flex Plan, including any insurance contracts or other benefit option summaries. If a claim or dispute concerning benefits payable under a specific benefit option arises, the claim or dispute will be disposed of in accordance with the claims procedures included in the documents for that benefit option, including all time limitations thereunder. However, if no claims procedures are included in the benefit option summary, or claims procedures provided in the summary do not satisfy all of the requirements of law, the below claims procedures will apply. In addition, for any claim regarding eligibility for this Flex Plan, the below claims procedures will apply.

Claims for benefits must be made in a timely manner and as provided by the Flex Plan and the benefit option summaries, including any applicable insurance contracts. In all events, you must submit claims for medical, dental, vision, EAP or HCFS (referred to in these procedures as group health plans) benefits to the plan administrator (or its delegate) within one year from the date the service was provided. If you do not submit such a claim within one year from the date the service was provided, you will be ineligible to receive reimbursement from the applicable benefit option for any expenses incurred, and you will be responsible for payment of all expenses incurred.

The plan administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide claims under this Flex Plan. References to the plan administrator hereunder will be deemed to apply to a third-party claim administrator to the extent that the plan administrator has delegated responsibility for review of the claim to such claim administrator by insurance contract or otherwise.

You may authorize someone else to file and pursue a claim or appeal on your behalf. If you do so, you must notify the plan administrator (or, where delegated, the claim administrator) in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number and a statement indicating the extent to which he or she is authorized to pursue the claim and/or appeal on your behalf.

CLAIM DEFINITIONS

Adverse Determination (adverse benefit determination): Adverse determinations are also sometimes referred to in these procedures as "claim denials." An adverse determination includes a denial, reduction, termination of, failure to provide or make payment (in whole or part) for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on:

- A determination of your eligibility to participate in the Flex Plan or any benefit option;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-inquiry exclusion, network exclusion or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational or not medically necessary or appropriate.

For group health plans, a denial, reduction or termination of or a failure to provide or make a payment (in whole or in part) for a benefit can include a pre-service claim, post-service claim or a concurrent care claim. Failure to make a payment in whole or in part includes any instance where the benefit option pays less than the total amount of expenses submitted with regard to a claim, including a denial of part of the claim due to the terms of the benefit option regarding copayments, deductibles or other cost-sharing requirements. An adverse determination also includes any rescission of coverage.

Appeal: An appeal is an oral or written request for review of an adverse benefit determination or an adverse action by the claim administrator, its employees or an in-network provider.

Complaint: A complaint is an expression of dissatisfaction by you either orally or in writing.

Concurrent Care Claim: A concurrent care claim is a group health plan claim for which the plan administrator approves ongoing treatment to be provided over a period of time.

Inquiry: An inquiry is a general request for information regarding claims, benefits or membership.

Post-service Claim: A post-service claim is any group health plan claim for a benefit for medical care previously provided to you.

Pre-service Claim: A pre-service claim is any group health plan claim for a benefit with respect to which the applicable benefit option requires you to obtain approval in advance of receiving the medical care.

Relevant Document: The document, record or other information that:

- Was relied on in making the benefit determination;
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether it was relied on;
- Demonstrates compliance with administrative processes and safeguards; or
- In the case of a benefit option providing disability benefits, constitutes a statement of policy or guidance with respect to the benefit option concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied on in making the benefit determination.

Rescission of Coverage: A rescission is a cancellation or discontinuance of coverage that has retroactive effect; provided, however, a cancellation or discontinuance will not be a rescission if:

- The cancellation or discontinuance of coverage has only prospective effect, or
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Urgent Care Claim: An urgent care claim is any claim for medical care under a group health plan with respect to which the applicable time periods for the plan administrator to make a non-urgent service claim determination could either:

- Seriously jeopardize your:
 - Life or health; or
 - Ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without urgent care or treatment. The plan administrator (or, if delegated, the claims administrator) defers to the attending provider as to whether a claim is an urgent claim.

CLAIM PROCEDURES

Notice After a Claim Is Filed

If your claim for benefits under any benefit option offered under the Flex Plan is denied, in whole or in part, the plan administrator (or, if delegated, claims administrator) must give you a written notice of the denial within a reasonable amount of time after the claim is received. (References to plan administrator in this chart are intended to refer, where appropriate, to any delegated claims administrator).

Benefit Option	Timeframe for Review of Initial Claim	Extension of Time
Group Health Plan Pre-Service Claim that is not an urgent care claim	An initial decision will be made within 15 calendar days after your claim is filed. If insufficient information is provided to enable the plan administrator to make a determination on a pre-service claim, the plan administrator will notify you of the benefit option's requirements for a pre-service claim unless you do not specify a medical condition or symptom or the specific treatment, service or product for which a determination is requested.	The 15-day period for making a decision may be extended, at the discretion of the plan administrator, for a second 15-day period if written notice is furnished to you before the termination of the initial period, indicating the special circumstances requiring the extension and the date a final decision is expected. If the extension is needed because you did not submit the necessary information, the notice will describe the required information. You have at least 45 days from the receipt of the notice to provide the information, and the period of time for deciding the claim is put on hold until the required information is provided. Pre-service claims for urgent care will be treated as urgent care claims (see below).
Group Health Plan Urgent Care Claim (including pre-service claims for urgent care)	An initial determination will be made as soon as possible, taking into account the medical circumstances, but no later than 72 hours after your claim is filed. If insufficient information is provided to enable the plan administrator to make a determination regarding whether or to what extent benefits are covered or payable, the plan administrator will notify you as soon as possible, but no later than 24 hours after its receipt of your urgent care claim, of the specific information necessary to enable the plan administrator to make a decision on your claim. You will then have a reasonable amount of time to provide the requested information, but no less than 48 hours after notification by the plan administrator (or its delegate) of the deficiency. The plan administrator will then notify you of its determination within 48 hours after the earlier of its receipt of the requested information or the end of the period within which you were requested to provide such additional information.	Does not apply.

Benefit Option	Timeframe for Review of Initial Claim	Extension of Time
Group Health Plan Post-Service Claim and HCFSA Claim	An initial determination will be made on your claim within 30 calendar days after the claim is filed, unless an extension of up to 15 days is necessary due to matters beyond the control of the plan administrator.	The 30-day period for making a decision may be extended, at the discretion of the plan administrator, for a second 30-day period, provided written notice is furnished to you before the termination of the initial period, indicating the special circumstances requiring such extension and the date a final decision is expected. If the extension is needed because you did not submit the necessary information, the notice will describe the required information. You have at least 45 days from the receipt of the notice to provide the information, and the period of time for deciding the claim is put on hold until the required information is provided.
Group Health Plan Concurrent Care Claim	In general, concurrent care claims are treated as pre-service care claims (see above). However, if a group health plan benefit option reduces or no longer covers a previously-approved treatment or course of treatments before the end of the approved period of time for the treatment or course of treatments, you will be notified of the reduction or termination of coverage sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination before such benefit is reduced or terminated. See “Appeal Procedure for an Adverse Determination on Your Claim” for more information.	Does not apply.
Dental or Vision Claim	An initial determination will be made on your claim within 30 calendar days after the claim is filed, unless an extension of up to 15 days is necessary due to matters beyond the control of the plan administrator.	If an extension is necessary, the plan administrator will notify you and the provider of the extension and the reason it is necessary within the original 30-day period. If an extension is needed because either you or the provider did not submit information necessary to decide the claim, the notice of extension will specifically describe the required information. You have at least 45 days from receipt of the notice to provide the specified information or ensure that the provider delivers it.

Benefit Option	Timeframe for Review of Initial Claim	Extension of Time
Claim for BTA or Disability Claim Under STD, LTD or Life and AD&D	You will be notified within a reasonable period of time, but no later than 45 days after your claim is received, unless an extension of up to 30 days is necessary due to matters beyond the control of the plan administrator.	If an extension is necessary, you will be notified before the 45-day period is over. The extension notice will indicate the circumstances requiring the extension of time and the date by which a decision on the claim is expected. If a decision cannot be made within the first 30-day extension period because of matters beyond the control of the plan administrator, the period for making the decision may be extended a second time for up to 30 days, provided you are given notice before the first extension period is over. The notice of any second 30-day extension will indicate the circumstances requiring the extension and the date a decision on your claim is expected. Any extension notice will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be given up to 45 days to provide the additional information, and the period of time for deciding your claim will be tolled until the required information is provided. If the information is not timely provided, your claim may be decided without the information that has been requested.
Claim for Death or Non-Disability Under Life and AD&D and DCFSA	If your claim is wholly or partially denied (a denial is also referred to as an adverse determination), you will be notified of the adverse determination within 90 days after the claim is received, unless special circumstances require an extension of time.	If an extension is required, you will be given written notice of the extension before the 90-day period is over. The extension notice will indicate the special circumstances that require an extension and the date a decision on your claim is expected. Only one 90 day extension is permitted.

Content of an Adverse Determination Notice

You will be given written or electronic notice of an adverse determination that includes:

- The specific reason or reasons for the denial and a description of the standard, if any, that was used in denying the claim;
- Specific references to pertinent Flex Plan or benefit option summary provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- An explanation of this Flex Plan's Claim and Appeal Procedure, available external review process and the applicable time limits. The description of the claim procedure includes information regarding how to initiate an appeal and a statement of your right to bring a civil action under Section 502(a) of ERISA following a claim denial if you choose to appeal the claim denial.

The notice will also include the following for group health plan claims:

- Information sufficient to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), the diagnosis code, the treatment code and the corresponding meaning of the codes;
- The denial code and an explanation of the code;
- The contact information for any applicable consumer assistance office established under Section 2793 of the Public Health Service Act to assist you; and
- In the case of an urgent care claim, a description of the expedited review process.

The notice will also include the following for both disability and group health plan claims:

- Any specific rule, guideline or protocol that was relied on, or a statement that such rule, guideline or protocol was relied on and that you may request a copy of such rule, guideline or protocol free of charge; and
- If the denial of a claim is based on a medical necessity or experimental treatment exclusion, an explanation of the scientific or clinical judgment, or a statement that you may request such explanation free of charge.

Access to Documents on Request

You may request and receive, free of charge, reasonable access to and copies of relevant documents, records and other information in the plan administrator's possession. Relevant documents, records and other information are those that:

- Were relied on in making the benefit determination;
- Were submitted, considered or generated in the course of making the benefit determination;
- Demonstrate compliance with the Flex Plan's or benefit option's administrative processes or safeguards; or
- In the case of a group health plan claim, constitute a statement of the Flex Plan's or benefit option's policy or guideline regarding the benefits for your diagnosis, whether or not relied on.

Full and Fair Review

You will be entitled to review your claim file and to present evidence and testimony as part of the claim and appeal process. In addition to complying with the requirements of 29 CFR 2560.503-1(h)(2):

- The plan administrator will provide you, free of charge, with any new or additional evidence considered, relied on or generated by the Flex Plan (or at the direction of the Flex Plan) in connection with the claim; such evidence to be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided under 29 CFR 2560.503-1(i) to give you a reasonable opportunity to respond before that date; and
- Before the plan administrator can issue a final adverse determination based on a new or additional rationale, you will be provided, free of charge, with the rationale, as soon as possible and sufficiently in advance of the date on which the notice of final benefit determination is required to be provided under 29 CFR 2560.503-1(i) to give you a reasonable opportunity to respond before that date.

In addition to the requirements of 29 CFR 2560.503-1(b) - (h) regarding full and fair review, the plan administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claim adjudicator or medical expert) will not be made based on the likelihood that the individual will support the denial of benefits.

The "full and fair review" requirements provided above will apply to the internal review and appeal procedures.

Important

Unless there are special circumstances, this administrative appeal process must be completed **before** you begin any legal action regarding your claim.

Appeal Procedure for an Adverse Determination on Your Claim

If your claim is denied and you want to appeal that decision, it is important to follow the Flex Plan's appeal procedures. If you do not follow these procedures, you may be giving up important legal rights, such as the ability to file a claim in a court of law. If the procedures below are exhausted and you are not satisfied with the decision that has been made, you have the right to file a lawsuit. These review and appeal procedures are governed by federal regulations. If anything described below is contrary to what federal regulations and other federal guidance would require, the federal information will control. Definitions applicable to these procedures appear at the start of this section.

Appeals of adverse determinations with respect to benefits under a group health plan benefit option must be made in writing (except for urgent care claims, which may be made orally as well) to the plan administrator's (or, if delegated, claim administrator's) address and must contain the reasons that you believe that you are entitled to such benefits as well as any additional information or documentation to support your claim for benefits. Such appeals will be subject to the following requirements:

Benefit Option	Timeframe for Submitting Your Appeal
Group Health Plan Pre-Service, Urgent Care, Post-Service or Concurrent Care Claims or Dental, Vision, BTA and HCFA Claims	You must submit your written appeal within 180 days after you receive your notice of an adverse determination. The review given to your appeal will not afford deference to the initial adverse determination and will be conducted by an appropriate fiduciary who is not the individual who made the adverse determination that is the subject of the appeal, nor the subordinate of such individual. If the appeal involves an adverse determination that is based in whole or in part on a medical judgment, including determinations of whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the fiduciary will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved or in medical judgment. This professional will be an individual who was not consulted in connection with the adverse determination that is the subject of your appeal nor a subordinate of any such individual. The Flex Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Flex Plan in connection with the adverse determination, without regard to whether the advice was relied on in making the determination. If your appeal relates to a medical claim involving urgent care, you will have an opportunity to expedite your appeal and the review procedure. In the case of urgent care, your appeal may be submitted orally or in writing, and necessary information, including the decision that is made with respect to the appeal, may be given by telephone, facsimile or other similar expeditious method. If your appeal relates to a medical claim in which concurrent care has been reduced or terminated, you will not necessarily be given 180 days to submit an appeal. Rather, based on the particular circumstances, you will be given a reasonable period of time to appeal before the benefit is reduced or terminated.

Benefit Option	Timeframe for Submitting Your Appeal
Disability Claim Under STD, LTD or Life and AD&D	You must submit your written appeal within 180 days after you receive your notice of an adverse determination. The review given to your appeal will not afford deference to the initial adverse determination and will be conducted by an appropriate fiduciary who is not the individual who made the adverse determination that is the subject of the appeal, nor the subordinate of such individual. If the appeal involves an adverse determination that is based in whole or in part on a medical judgment, including determinations of whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the fiduciary will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved or in medical judgment. This professional will be an individual who was not consulted in connection with the adverse determination that is the subject of your appeal nor a subordinate of any such individual. The Flex Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Flex Plan in connection with the adverse determination, without regard to whether the advice was relied on in making the determination.
DCFSA Claim	You must submit your written appeal within 60 days after you receive the notice of an adverse determination.
Death or Non-Disability Claims in Life and AD&D	You must submit your written appeal within 90 days after you receive the notice of an adverse determination.

Review of the Appeal You Submit

If your appeal of an adverse determination under any benefit option is denied, in whole or in part, the plan administrator (or, if delegated, claims administrator) must give you a written notice of the denial within a reasonable amount of time after the appeal is received:

Benefit Option	Timeframe for Review of Your Appeal	Extension of Time
Group Health Plan Pre-Service Claim	Decisions on appeals must be made within 30 calendar days following receipt of the appeal of the adverse determination.	Does not apply
Group Health Plan Urgent Care Claim	Appeals of adverse determinations may be submitted orally or in writing. Decisions on appeals must be made within 72 hours following receipt of the appeal of the adverse determination.	Does not apply
Group Health Plan Post-Service, Dental or Vision Claim	Decisions on appeals must be made within 60 calendar days following receipt of your appeal of the adverse determination.	Does not apply
Group Health Plan Concurrent Care Claim	If you wish to extend a treatment or course of treatments that was previously approved by the plan administrator, but a group health plan benefit option subsequently reduces or terminates coverage of such treatment or course of treatments before the expiration of the period of time or number of treatments for which such treatment or course of treatment was approved, you may appeal the reduction or termination of coverage as an adverse determination. If such appeal would be an urgent care claim, you should notify the plan administrator at least 24 hours before the expiration of the previously-approved period of time or number of treatments to request extended coverage. If you adhere to the	Does not apply

Benefit Option	Timeframe for Review of Your Appeal	Extension of Time
	deadlines in the previous sentence, a decision on such appeal must be made within 72 hours after its receipt by the plan administrator. In all other instances, appeals regarding an adverse determination involving concurrent care claims will be treated, as applicable, as pre-service claim appeals, urgent care claim appeals or post-service claim appeals, and subject to the timeframes listed above, as applicable.	
Disability Claim Under STD, LTD, Life and AD&D or all BTA Claims	Notice of the decision made on the appeal will be given no later than 45 days after receipt of the appeal, unless special circumstances require an extension of time for processing your appeal.	If an extension of time is required, written notice of the extension will be given before the end of the initial 45-day review period. The extension period will not exceed another 45 days. The extension notice will indicate the special circumstances requiring an extension and the date a decision on your appeal is expected. If the extension is necessary because of your failure to submit information necessary to decide your appeal, the period for making the decision will be tolled from the date on which the notice of the extension is sent, until the date you respond to the request for additional information. If the requested information is not provided, your appeal may be decided without the necessary information.
DCFSA, HCFSA, or Death or Non-Disability Claims in Life and AD&D Claim	Except as provided below for decisions by a committee or board, you will be notified of the benefit determination on review no later than 60 days after receipt of the appeal, unless special circumstances (for example, the need to hold a hearing) require an extension of time for processing the appeal.	If it is determined that an extension of time is required, written notice of the extension will be furnished before the end of the initial 60-day review period. The extension will not exceed an additional 60 days. The extension notice will indicate the special circumstances requiring an extension and the date a decision on your appeal is expected. If the extension is necessary because of your failure to submit information necessary to decide your appeal, the period for making the decision will be tolled from the date on which the notice of the extension is sent, until the date you respond to the request for additional information. If the requested information is not provided, your appeal will be decided without the necessary information.

Continued Coverage During Group Health Plan Appeal

You will be entitled to continued coverage pending the outcome of your appeal to the extent mandated by the Health Care Reform Law. For this purpose, the Flex Plan will comply with the requirements of ERISA Section 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. If you are receiving urgent care or an ongoing course of treatment, you may be allowed to proceed with an expedited external review at the same time as the specific benefit option's or Flex Plan's appeals

process, under either a state external review process or the federal external review process, in accordance with the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners, as applicable.

Content of Notice of Decision Made on Appeal

You will be given written or electronic notice of any decision that is made. If the decision is an adverse determination, the notice will include:

- The specific reason or reasons for the denial, including for group health plans the denial code and an explanation of the code, and a description of the standard, if any, that was used in denying the claim;
- Specific references to pertinent Flex Plan or benefit option summary provisions on which the denial is based;
- A statement that you are entitled to receive, on request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered and your right to obtain information about a voluntary appeal and the applicable time limits; and
- A statement of your right to bring an action under Section 502(a) of ERISA.

For group health plan claims:

- The notice will also include:
 - Information sufficient to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), the diagnosis code, the treatment code and the corresponding meaning of the codes;
 - A statement of the benefit option's external review process and the applicable time limits, including information regarding how to initiate the process; and
 - The contact information for any applicable consumer assistance office established under Section 2793 of the Public Health Service Act to assist you.
- The review will conform to the following:
 - The review of your claim must be performed by someone who is neither the original decision-maker nor a subordinate of the original decision-maker. In reviewing the initial decision, the decision-maker may not give deference to the initial decision and he or she must consider all information relevant to your claim, regardless of whether such information was relied on or available when the original decision was made. The decision-maker must also consider any information submitted by you; and
 - If denial of the group health plan claim was based on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the decision-maker reviewing your claim will consult with a healthcare professional with appropriate training and experience in the field of medicine involved in the medical judgment. Medical or vocational experts whose advice was obtained on the Flex Plan's behalf in connection with denial of a claim will be identified for you. If a healthcare professional is engaged for purposes of consultation in deciding an appeal of denial of a claim, such professional will not be the same individual (or a subordinate of such individual) who was consulted in the initial denial of your claim.

The notice will also include the following for disability claims:

- If an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion will be given; or a statement that such rule, guideline, protocol or other similar criterion was relied on in making the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to you on request; and
- If the adverse determination is 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,

applying the terms of the Flex Plan or benefit option documents to your medical circumstances or a statement that such explanation will be provided free of charge on request.

Finality of Review on Appeal: You will not be entitled to challenge the plan administrator's determinations in judicial or administrative proceedings without first complying with these claim procedures. The decisions made pursuant to these procedures are final and binding on you, your beneficiaries and any other party; provided, however, that if you have exhausted the administrative claim procedure set forth in the benefit option summary or Flex Plan, as appropriate, you may seek review of your claim before a court of competent jurisdiction within 12 months after the date your claim is finally denied.

Strict Compliance Required: The Flex Plan intends to strictly comply with the applicable Healthcare Reform Law requirements and federal regulations relating to internal claim and appeals processes.

External Review for Group Health Plan Claims: Following a group health plan claim denial, other than a claim denial relating to you or your beneficiary's eligibility, you may also be entitled to initiate a claim for an external review under either state or federal external review procedures. The Flex Plan intends to comply with the state and federal external review procedures, as applicable, and you will be provided with information describing your rights to file a request for an external review of a claim denial in accordance with these procedures.

Communications: For purposes of these procedures, communications to the plan administrator may be addressed to the claim administrator designated in **"Claim Administrators and Service Providers."** If none is designated, then to the address set forth in the section called **"Plan Administration."**



Proof of Loss

Except to the extent that a different date is provided in the separate summary for the benefit option or this SPD, written proof covering the occurrence, the character and the extent of loss must be furnished to the plan administrator by the end of the calendar year following the calendar year in which the loss occurred. Failure to furnish notice of proof within the required time will not invalidate nor reduce any claim if it is shown that you gave notice or proof as soon as was reasonably possible, but in no event later than one year from the time proof is otherwise requested. The plan administrator will furnish such forms as are usually furnished by it for filing proofs of loss.

Failure to insist on compliance with any provision of this procedure at any given time or times or under any given set or sets of circumstances does not operate to waive or modify such provisions, or in any matter whatsoever to make the procedures unenforceable, whether the circumstances are or are not the same.

For Medical and Prescription Drug Coverage

Standard External Review

You or your authorized representative may make a request for a standard external review or expedited external review of an adverse benefit determination or final internal adverse benefit determination by an independent review organization (IRO).

- **Request for External Review:** Within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination from the plan administrator, you or your authorized representative must file your request for standard external review with the plan administrator. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the

receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday.

- **Preliminary Review:** Within five business days following the date of receipt of the external review request, the plan administrator must complete a preliminary review of the request to determine whether:
 - You are, or were, covered under the benefit option at the time the healthcare item or service was requested or, in the case of a retrospective review, were covered under the benefit option at the time the healthcare item or service was provided;
 - The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the benefit option or this Flex Plan (e.g., worker classification or similar determination);
 - You have exhausted the plan administrator's internal appeal process, unless you are not required to exhaust the internal appeal process under the interim final regulations. Please see the "Exhaustion" section for additional information and exhaustion of the internal appeal process; and
 - You or your authorized representative has provided all the information and forms required to process an external review.

You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration—toll-free number 1-866-444-EBSA (3272).

- **Referral to Independent Review Organization:** When an eligible request for external review is completed within the time period allowed, the plan administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the plan administrator will take action against bias and to ensure independence. Accordingly, the plan administrator must contract within at least three IROs for assignments under the benefit option and rotate claim assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the benefit option and plan.
- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- Within five business days after the date of assignment of the IRO, the plan administrator must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan administrator to timely provide the documents and information must not delay the conduct of the external review. If the plan administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the plan administrator and you or your authorized representative.

- On receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the plan administrator. On receipt of any such information, the plan administrator may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan administrator decides, on completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review on receipt of the notice from the plan administrator.
- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - Your medical records;
 - The attending healthcare professional's recommendation;
 - Reports from appropriate healthcare professionals and other documents submitted by the plan administrator, you or your treating provider;
 - The terms of the benefit option summary and this Flex Plan to ensure that the IRO's decision is not contrary to the terms of the benefit option or this Flex Plan, unless the terms are inconsistent with applicable law;
 - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
 - Any applicable clinical review criteria developed and used by the claim administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the plan administrator and you or your authorized representative.
- The notice of final external review decision will contain:
 - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount [if applicable], the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the plan administrator and you or your authorized representative;
 - A statement that judicial review may be available to you or your authorized representative; and
 - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

- After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for exam by the plan administrator, state or federal oversight agency on request, except where such disclosure would violate state or federal privacy laws, and you or your authorized representative.
- **Reversal of Plan's Decision:** On receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the plan administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

- **Request for Expedited External Review:** The plan administrator must allow you or your authorized representative to make a request for an expedited external review with the plan administrator at the time you receive:
 - An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or healthcare item or service for which you received emergency services, but have not been discharged from a facility.
- **Preliminary Review:** Immediately on receipt of the request for expedited external review, the plan administrator must determine whether the request meets the reviewability requirements in the "Standard External Review" section above. The plan administrator must immediately send you a notice of its eligibility determination that meets the requirements in "Standard External Review."
- **Referral to Independent Review Organization:** On a determination that a request is eligible for external review following the preliminary review, the plan administrator will assign an IRO pursuant to the requirements in the "Standard External Review" section above. The plan administrator must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan administrator's internal claims and appeals process.
- **Notice of Final External Review Decision:** The plan administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision in accordance with the requirements in the "Standard External Review" section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the plan administrator and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the final internal adverse benefit determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the plan administrator waives the internal review process or the plan administrator has failed to comply with the internal claim and appeals process. You also have the right to pursue any available remedies under 502(a) of ERISA or under state law.

External review may not be requested for an adverse benefit determination involving a claim for benefits for a healthcare service that you have already received until the internal review process has been exhausted.



Payment of Group Health Claims and Assignment of Benefits

All group health claims will be paid to you, unless assigned. Any benefits payable on or after your death will be paid to your estate.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incurs expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided under one or more of the benefit options under this Flex Plan, you agree:

- The plan administrator has the right to reimbursement for all benefits the plan administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total eligible charge or the provider's claim charge for covered services for which this Flex Plan has provided benefits to you, reduced by any average discount percentage (ADP) applicable to your claims.
- The plan administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits this Flex Plan provided for that sickness or injury.

The plan administrator will have the right to first reimbursement out of all funds you, your covered dependents or your legal representative is or was able to obtain for the same expenses for which this Flex Plan has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the claim administrator may reasonably require to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

RIGHT OF RECOVERY

If payment for claims exceeds the amount for which you are eligible under any benefit option of this Flex Plan, the plan administrator has the right to recover the excess of such payment from the provider or you.

LEGAL ACTIONS

No participant can bring an action at law or in equity to recover under the Flex Plan or any benefit option until more than 60 days after the date written proof of loss has been furnished according to the Flex Plan. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit under this Flex Plan is less than allowed by the laws of the state where you reside, the limit is extended to meet the minimum time allowed by such law.

PLAN ADMINISTRATION

This section provides you with information about how this Flex Plan is administered.

PLAN NAME AND NUMBER

Following is information on this Flex Plan's legal name, benefit options, funding and identification numbers are:

Plan Name	Plan Type, Funding and Administration	Plan Identification Number
Littelfuse, Inc. Flexible Benefit Plan	The following benefit options are fully-insured through a third-party insurance company: ■ Vision ■ Life and AD&D ■ LTD ■ BTA ■ EAP ■ Legal and ID theft protection services The following benefit options are self-funded: ■ Medical plan: ● Premier PPO, including prescription drug program ● Choice PPO, including the prescription drug program ● Advantage PPO + HSA, including the prescription drug program ■ Dental plan ■ Flexible spending account (FSA) plan: ● HealthCare Flexible Spending Account (HCFSA) ● Dependent Care Flexible Spending Account (DCFSA) ■ Health Savings Account (HSA) ■ Short-Term Disability (STD) plan Self-funded benefits are paid from associate contributions, as applicable, and from the general assets of the company, as needed. The type of administration depends on the particular benefit option. If the benefit option is insured, then it is administered by the insurer. If the benefit option is self-insured, then it is administered by the company, as plan administrator, with the assistance of certain third parties engaged by the company.	525

Most, but not all, of the benefit options offered under this Flex Plan are subject to ERISA. If a benefit option is not subject to ERISA, it is described as part of this Flex Plan for purposes of convenience and because there may be other applicable laws, such as the Internal Revenue Code, that require a written document. For example, the DCFSA and legal and ID theft protection services plan are described in this SPD; however, they are not subject to ERISA.

The terms and conditions of these benefit options are documented in the applicable summaries, including the applicable benefit option's summary and the insurance contracts purchased to provide benefits. The insurance contracts and other summaries setting forth the terms and conditions of each benefit option are incorporated by reference into this Flex Plan.

We may add or remove benefit options provided as a component of the Flex Plan at any time. We may also choose to offer one or more wellness programs or disease management programs from time to time as a part of the Flex Plan and as communicated to participants. For example, we offer a physical activity tracking device wellness subsidy.



Separate Plan

Although reprinted within the Littelfuse, Inc. Flexible Benefit Plan document and intended to be combined under this “wrap” plan for purposes of the annual report requirement (Form 5500) and for compliance with certain other laws:

- The HCFSAs are intended to be a separate group health plan and qualify as a medical reimbursement plan under Code Section 105 and the regulations issued by the U.S. Department of Treasury thereunder and will be interpreted in a manner consistent with that Code Section.
- The DCFSAs are intended to qualify under Code Section 129 and will be interpreted in a manner consistent with that Code Section, and is a separate plan for purposes of requirements imposed by Code Section 129.

PLAN SPONSOR AND PLAN ADMINISTRATOR

Littelfuse, Inc.

Address: 8755 W. Higgins Road, Suite 500, Chicago, IL 60631, Attn: U.S. Benefits Manager

Phone: 1-773-628-1000

Email: UBenefits@Littelfuse.com

The operation of this Flex Plan is under the supervision of the company, as plan administrator. The Littelfuse Benefits Department carries out the administration of the Flex Plan on our behalf. It keeps the records for the Flex Plan and is responsible for the administration of the Flex Plan. We may engage one or more third parties to assist in the administration of the Flex Plan and the benefit options, and may delegate any of its duties or powers to a third party.

The Littelfuse Benefits Department will also answer any questions you may have about this Flex Plan or benefit options offered under this Flex Plan. You may also contact the claim administrator or service provider for the particular benefit option for additional information about a specific benefit option. The Littelfuse Benefits Department may adopt such rules as it deems desirable for the administration of this Flex Plan or any of the benefit options.

It is one of our principal duties as the plan administrator to see that this Flex Plan is carried out in accordance with its terms, and for the exclusive benefit of associates entitled to participate in this Flex Plan. We have the full power to administer this Flex Plan in all of its details subject, however, to the pertinent provisions of the Code. Our powers include the following authority, in addition to all other powers provided by this Flex Plan:

- Make and enforce such rules and regulations as the plan administrator deems necessary or proper for the efficient administration of this Flex Plan;
- Interpret this Flex Plan, which interpretations made in good faith will be final and conclusive on all persons claiming benefits of this Flex Plan;
- Decide all questions concerning this Flex Plan and the eligibility of any person to participate and to receive benefits provided by this Flex Plan and its underlying benefit options;
- Reject elections or limit contributions or benefits for certain highly compensated individuals or key employees to the extent it deems desirable to avoid discrimination under this Flex Plan or our cafeteria plan in violation of applicable provisions of the Code;
- Provide associates with a reasonable notification of their benefits under this Flex Plan;
- Establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and
- Appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering this Flex Plan.

Any procedure, discretionary act, interpretation or construction taken by us as plan administrator will be done in a nondiscriminatory manner based on uniform principles consistently applied and will be consistent with the intent that this Flex Plan and its underlying benefit options will continue to comply with the terms of the Code.

Under the terms of this Flex Plan, each claim administrator has been allocated full discretionary authority over benefit determinations. See **“Claim Administrators and Service Providers”** for the names and addresses of the claim administrators. Benefits under this Flex Plan will be paid only if the plan administrator or the claim administrator decides in its discretion that under the terms of this Flex Plan the claimant is entitled to the benefit.

Named Fiduciary

The company is hereby designated as a “named fiduciary,” within the meaning of ERISA Section 402(a), with respect to the operation and administration of the Flex Plan and is responsible, except to the extent provided below, for administering the Flex Plan in accordance with its terms. For each of the insured benefit options, the insurance company is a “named fiduciary” with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.

Delegation

We may establish procedures for the designation of persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the Flex Plan. If any fiduciary responsibility is allocated or delegated to any person, no named fiduciary is liable for any act or omission of such person, except as provided in ERISA Section 405(c).

Expenses of the Plan Administrator

The plan administrator serves without compensation for its services. The Flex Plan will pay all plan expenses, including, but not limited to, fees of legal counsel, accountants and other specialists, plan communication and recordkeeping costs, plan audit fees, claims review (such as IROs) and vendor searches, incurred by the plan administrator or its delegates in the performance of their duties, to the extent such expenses are not paid by the company and sufficient plan assets are available (including that portion of any distribution from an insurance issuer or similar, such as a refund, dividend, demutualization payment, rebate, excess surplus distribution, that the plan administrator determines constitutes plan assets and may be applied to the payment of plan expenses in accordance with ERISA). We will pay all

other non-plan expenses, including settlor expenses, incurred by the plan administrator or its delegates in the performance of their duties.



Affiliates

Unless the context requires otherwise (such as designations of the plan sponsor and plan administrator, and granting of powers to amend and terminate the Flex Plan), references to the company include any U.S. subsidiary or U.S. affiliate of the company. Affiliate means any entity which is a member of a controlled group of corporations with the company; under common control with the company; or a member of an affiliated service group with the company, as such terms are defined in Code Section 414. For purposes of this definition, the term affiliate will exclude SSAC, LLC.

AGENT FOR SERVICE OF LEGAL PROCESS

The agent for service of legal process is the Littelfuse Benefits Department at the address listed under "Plan Sponsor and Plan Administrator."

EMPLOYER IDENTIFICATION NUMBER

36-3795742

PLAN YEAR

January 1 through December 31

CLAIM ADMINISTRATORS AND SERVICE PROVIDERS

We use different claim administrators and service providers for the Flex Plan as shown below:

Claim Administrator and/or Service Providers	For	Contact Info for Claims
Littelfuse, Inc. U.S. Benefit Manager 8755 W. Higgins Road, Suite 500 Chicago, IL 60631 1-773-628-1000 UBenefits@Littelfuse.com	Eligibility appeals and wellness incentives	Littelfuse, Inc. U.S. Benefit Manager 8755 W. Higgins Road, Suite 500 Chicago, IL 60631 1-773-628-1000
Blue Cross Blue Shield of IL 1020 W. 31 st Street Downers Grove, IL 60515 1-800-526-6593 bcbsil.com	BCBSIL members' medical claims, benefit amounts and terms/provisions of the medical benefit option	Blue Cross Blue Shield of IL P.O. Box 805107 Chicago, IL 60680-4112 1-800-526-6593
Tufts Health Plan 1 Wellness Way Canton, MA 02021 1-800-462-0224 tuftshealthplan.com	Tufts Health Plan members' medical claims, benefit amounts and terms/provisions of the medical benefit option	Tufts Health Plan 1 Wellness Way Canton, MA 02021 1-800-526-6593
Prime Therapeutics P.O. Box 14624 Lexington, KY 40512-4624 1-800-423-1973	BCBSIL members' prescription drug program claims, benefit amounts and terms/provisions of the program under the medical benefit option	Prime Therapeutics P.O. Box 25136 Lehigh Valley, PA 18002-5136 1-800-423-1973

Claim Administrator and/or Service Providers	For	Contact Info for Claims
HSA Bank P.O. Box 939 Sheboygan, WI 53082 1-855-731-5220 hsabank.com	HSA administration under the Advantage PPO + HSA medical benefit option	NA
PayFlex (HealthHub) 10802 Farnam Drive Suite 100 Omaha, NE 68154 1-800-284-4885 payflex.com	■ COBRA administration for all COBRA benefits ■ Commuter Benefit ■ FSA claims, reimbursement amounts and terms/provisions of the FSA plan	PayFlex Systems USA Inc. P.O. Box 3039 Omaha, NE 68103-3039 Commuter Benefit 844-729-3539 FSA Claim Fax: 1-402-231-4310 1-800-284-4885 COBRA Claim 1-800-359-3921
Delta Dental 111 Shuman Blvd Naperville, IL 60563 1-800-323-1743 deltadentalil.com	Dental claims, benefit amounts and terms/provisions of the dental plan	Delta Dental P.O. Box 5402 Lisle, IL 60532 1-800-323-1743
EyeMed Vision Care, LLC 4000 Luxottica Place Mason, OH 45040 1-866-939-3633 eyemedvisioncare.com	Vision claims, benefit amounts and terms/provisions of the vision plan	Initial Claim FAA/EyeMed Vision Care, LLC Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 1-866-723-0513 Claim Appeal Documentation FAA/EyeMed Vision Care, LLC Attn: Quality Assurance Dept. 4000 Luxottica Place Mason, OH 45040 Fax: 1-513-492-3259
Cigna 1-800-754-3207	Accidental injury, critical illness and hospital indemnity claims, benefit amounts and terms/provisions of the supplemental health benefits.	supphealthclaims.com
LifeWorks 1-888-267-8126 Login.lifeworks.com Username and Password: Littelfuse	Employee Assistance Program (EAP) claims, benefit amounts and terms/provisions of the EAP	NA
Chubb Group of Insurance Companies P.O. Box 4700 Chesapeake, VA 23327-4700 1-888-987-5920 chubb.com/travelhelp/eb	Business Travel Accident (BTA) claims, benefit amounts and terms/provisions of the BTA plan, including travel assistance	Chubb Group of Insurance Companies Claims Service Center P.O. Box 4700 Chesapeake, VA 23327-4700
New York Life Insurance Company	Basic life and AD&D, voluntary life and AD&D,	1-888-842-4462

Claim Administrator and/or Service Providers	For	Contact Info for Claims
1-888-842-4462 mynylgbs.com/auth	STD and LTD claims, benefit amounts and terms/provisions of each of these plans	
ARAG 1-800-247-4148 ARAGlegal.com/myinfo	Legal services claims and terms/provisions of the legal services plan	NA
Allstate 1-800-789-2720 myaip.com	ID theft protection services claims and terms/provisions of the ID theft protection services plan	

Insurance Control Clause

Certain benefit options offered under the Flex Plan are fully insured. Benefits are provided under a group insurance contract entered into between the company and the insurance company. Claims for benefits are sent to the insurance company. The insurance company is responsible for determining and paying claims, not the company. As the “named fiduciary” for benefit determinations under fully-insured benefit options, the insurance company has the discretionary authority to interpret the benefit option to make benefit determinations. The insurance company also has the authority to require eligible persons to furnish it with such information as the insurance company determines necessary for the proper administration of the benefit option. In the event of a conflict between the terms of the benefit option summaries or the Flex Plan and the terms of the insurance contract, the terms of the insurance contract will control as to those persons receiving coverage under such benefit option. For this purpose, the insurance contract will control in defining the persons eligible for the benefit option, the dates of their eligibility, the conditions which must be satisfied to become insured or otherwise participate in the benefit option, if any, the benefits that all persons covered by that benefit option are entitled to, and the circumstances under which the eligibility for the benefit option, and the underlying insurance, terminates.

Important Disclaimer

Benefits under the Flex Plan are provided pursuant to an insurance contract or benefit option summaries adopted by the company. If the terms of this document conflict with the terms of such insurance contract or benefit option summaries, then the terms of the insurance contract or benefit option summaries will control, rather than this document, unless otherwise required by law.

PLAN FUNDING

Unless otherwise required by law, contributions to the Flex Plan need not be placed in trust or dedicated to a specific benefit option, but may instead be considered general assets of the company until the premium expense required under the Flex Plan has been paid. Furthermore, and unless otherwise required by law, the company and the plan administrator are not required to maintain any fund or segregate any amount for the benefit of any participant, and neither you nor any other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the company from which any payment under the Flex Plan may be made.

Associate Contributions: Each associate must pay his or her share of the cost of benefit options covering the associate and his or her covered spouse, civil union partner and dependents under the Flex Plan. This is determined by the company from time to time. We will pay the remainder (if any) of the cost. Any designation of company premium amounts in open enrollment or other communications is intended as an estimate, not a fixed dollar amount, of our contributions.

For associates to pay this cost through salary reductions on a pre-tax basis, they must satisfy the requirements of our cafeteria plan. In some cases where the associate is not eligible for our cafeteria plan or where persons covered under a benefit option selected by the associate do not qualify for pre-tax benefits under the Code, we in our sole discretion, may allow the associate to pay all or part of the cost on an after-tax basis outside of our cafeteria plan (in some limited situations described in the cafeteria plan, after-tax payments may be made through the cafeteria plan).

We may, from time to time, implement or adopt one or more wellness programs or disease management programs under the Flex Plan that offer you the opportunity to qualify for discounts on the cost of benefit options or other financial incentives if you, and/or your spouse or civil union partner (if applicable) participate in the wellness program or satisfy certain health standards. If you and/or your spouse or civil union partner (if applicable) choose to participate, or stop or otherwise fail to qualify in such a program, any adjustments will be automatically applied to the cost of your benefit options and to your salary reductions.

Company Contributions: We will make our contributions in an amount that (in our sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. With respect to the insured component benefit options, we will pay our contribution and your contributions to the insurer. With respect to benefit options that are self-funded, we will use these contributions to pay benefits directly to (or on behalf of) you or your eligible dependents from our general assets.

RIGHT TO AMEND OR TERMINATE THE PLAN

As the sponsor of the Flex Plan, we reserve the right to amend or terminate the Flex Plan or any benefit options, in whole or in part, at any time for any reason. In the event the Flex Plan is terminated, no further contributions will be made.

Unless prohibited by law, amendments may take effect retroactively. No amendment requires your, your dependent's, your beneficiary's or any other person's consent.

NO EMPLOYMENT GUARANTEE

The adoption and maintenance of the Flex Plan does not constitute a contract of employment between the company and you and is not a consideration for the employment of any person. Nothing contained in the Flex Plan gives you the right to be retained in our employ or limits our ability to discharge or take other appropriate action against you at any time without regard to the effect of such discharge or action on your rights under the Flex Plan.

MISCELLANEOUS PLAN PROVISIONS

Action by the Company. Whenever under the terms of the Flex Plan we are permitted or required to do or perform any act or matter or thing, it may be done and performed by the company's Executive Vice President, Chief Legal and Human Resources Officer.

Company Protective Clauses. On the failure of any person or the company to obtain the insurance contemplated by the Flex Plan (whether as a result of negligence, gross neglect, or otherwise), benefits will be limited to the insurance premiums, if any, that remain unpaid for the coverage under the benefit option for the period in question and the actual insurance proceeds, if any, received by us or you as a result of your claim. We will not be responsible for the validity of any insurance contract issued under the Flex Plan or for the failure on the part of the insurer to make payments provided for under any insurance contract. Once insurance is applied for or obtained, we will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by us.

Company's Right to Distributions. To the fullest extent permitted by ERISA and other applicable law, any distribution from an insurance issuer or similar payment, such as an insurance company, to its policyholders will be payable solely to the company. Distributions for this purpose include, but will not be

limited to, refunds, dividends, demutualization payments, rebates and excess surplus distributions, and will not include payments or reimbursement for your claims for benefits.

No Guarantee of Tax Consequences. We make no commitment or guarantee that any amounts paid to or for your benefit under the Flex Plan will be excludable from your gross income for federal or state income tax purposes or that any other federal or state tax treatment will apply to or be available to you. It is your obligation to determine whether each payment under the Flex Plan is excludable from your gross income for federal and state income tax purposes, and to notify the company if you have reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of participants under the Flex Plan will be legally enforceable.

Nontransferability of Interests. Except as otherwise required by law, your rights to benefits under the Flex Plan are not subject to your debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered.

YOUR ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Obtain, on written request to the plan administrator, copies of documents governing the operation of the Flex Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 series) and updated summary plan descriptions (SPDs). The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue healthcare coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Flex Plan because 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 Flex Plan for the rules governing your COBRA continuation coverage rights.

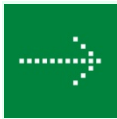
Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

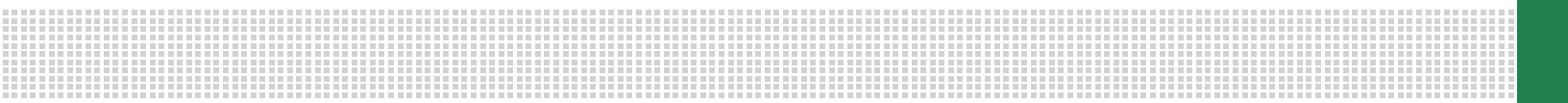
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Flex Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Flex Plan's claims procedures as described in this SPD. In addition, if you disagree with the Flex Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Flex Plan fiduciaries misuse the Flex Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.



Assistance with Your Questions

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



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USA

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