

Coldwater Creek Inc.

Flexible Benefits Plan

Flexible Spending Account (FSA) Summary Plan Description (SPD)

*Effective January 1, 2009
Revised January 1, 2009*

FLEXIBLE SPENDING ACCOUNTS

Flexible spending accounts (FSAs) allow you to set aside pretax dollars from your paycheck to pay for expenses not covered through your other benefits. When you put money into an FSA, you don't pay federal or FICA (Social Security) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

Coldwater Creek, the plan administrator/plan sponsor, offers two FSAs for all benefit-eligible employees:

- A health care FSA that allows you to set aside pretax dollars to pay for certain expenses not covered by your medical, dental and vision plans (for example, copays for office visits and the cost of orthodontia not fully paid by your dental plan);
- A dependent care FSA that allows you to set aside pretax dollars to pay for eligible dependent day care expenses for your child, disabled spouse or other disabled dependent (such as a parent) while you and your spouse work.

Plan benefits are funded through employee before-tax salary reduction contributions, as permitted by Internal Revenue Code Section 125. Coldwater Creek pays the administrative expenses of the plan to the extent those expenses are not paid from plan assets.

Participating in FSAs

When you choose to participate in an FSA, you decide how much you want to contribute through payroll deduction to either a health care or dependent care FSA, or both, and indicate the amount(s) on a Benefit Election Form. When the Employee Benefits Department receives your election form, it verifies your eligibility and transmits the information to payroll (so deductions can be taken from your paycheck) and to the third-party administrator, identified in the General Plan Information section of this document. The third-party administrator sets up your FSA and administers it for Coldwater Creek.

As you incur eligible expenses, you submit reimbursement request forms, receipts and other required documentation to the third-party administrator, and the third-party administrator reimburses you from your account. If the reimbursement is approved, a check is issued or a direct deposit transmitted the night your request is processed, and an explanation of reimbursement is mailed to your home.

Alternatively, you may elect to use an electronic payment card (debit card) to pay the expense. Contact the Employee Benefits Department or the third-party administrator for more information on procedures for obtaining a debit card and policies for debit card use.

You may submit reimbursement requests for eligible expenses incurred during the calendar year any time through March 31 of the following year—requests must be received by the third-party administrator no later than March 31. You may also submit multiple bills or receipts with one reimbursement claim form as long as you list them on the claim form.

Third-Party Administrator's Reimbursement Request Form and FSA Authorization for Automatic Reimbursement Deposits Form are available through the Employee Benefits Department. (See *Contact Information*.)

Who Is Eligible

You are eligible to participate in an FSA when you first become eligible for benefits, have a Change in Status Event, or enroll in an FSA during the annual open enrollment.

When You're First Eligible

You are first eligible to participate in an FSA when you become a benefit-eligible employee, which means you are working a minimum of 32 hours per week. Participation in the FSA will commence on the first of the month following the date of employment or the date you become benefits eligible.

When You Have a Change in Status Event

You have the opportunity to participate in an FSA or make changes to an existing FSA when one of the following Change in Status Events occur (the type of Change in Status Event determines the type of FSA for which you may become eligible):

- Change in your legal marital status due to marriage, legal separation, annulment, divorce or death of a spouse;
- Change in the number of your tax dependents due to birth, adoption or placement for adoption, or death of a dependent;
- Change in employment status for you, your spouse or a dependent due to:
 - termination or commencement of employment;
 - a reduction or increase in work hours;
 - a switch from salaried to hourly-paid, from union to non-union, or from part-time to full-time;
 - a strike or lockout;
 - the beginning of or return from unpaid leave of absence;
 - any other employment status change that affects FSA eligibility;
- Change that causes a dependent to satisfy or cease to satisfy the requirements for coverage due to age, marriage or any similar circumstances provided for in the benefit plans;
- Change due to certain judgments and court orders;
- Change in cost of dependent care due to a change in provider.

During the Annual Open Enrollment

You have the opportunity to enroll or re-enroll in an FSA during the annual open enrollment which is held in November or December of each year.

When and How to Enroll

You may enroll in an FSA when:

- You are first eligible for benefits;
- You have a Change in Status Event; or
- You make your benefit elections during the annual open enrollment.

When you enroll, you enroll for the calendar year (January 1-December 31). You must re-enroll each year during open enrollment to continue participating the following year. You may make changes to your FSAs during open enrollment, but changes outside of open enrollment are restricted. (For more information, see “When You Have a Change in Status Event.”)

Enrolling When First Eligible

You receive FSA information and a Flexible Spending Account Enrollment form when you first become eligible for benefits.

You must return your enrollment form within 31 days of your benefit-eligibility date to the Employee Benefits Department. (See *Contact Information*.) Your benefit-eligibility date is the day you first report to work as a new employee.

Your FSA information includes a direct-deposit form so you can have FSA reimbursements deposited directly to a checking or savings account if you choose. (You may opt not to have FSA reimbursements deposited directly when you first enroll, but can do so later by contacting the third-party administrator to set up direct-deposit.)

The Flexible Spending Account Enrollment form and FSA Authorization for Automatic Reimbursement Deposits Form are available from the Employee Benefits Department. (See *Contact Information*.)

Enrolling After a Change in Status Event

When you have a Change in Status Event (See “When You Have a Change in Status Event”), you may enroll in an FSA midyear if you're a benefit-eligible employee enrolling in an FSA for the first time that year.

You must submit a Flexible Spending Account Enrollment form within 31 days of the Change in Status Event to the Employee Benefits Department. (See *Contact Information*.) You may also submit a direct-deposit form so you can have FSA reimbursements directly deposited to a checking or savings account if you choose.

The Flexible Spending Account Enrollment form and FSA Authorization for Automatic Reimbursement Deposits Form are available from the Employee Benefits Department. (See *Contact Information*.)

Enrolling During Open Enrollment

During the annual open enrollment held in November or December of each year, you may make your FSA election for the following calendar year. Each year, you must re-enroll if you want to continue participating in an FSA the following year.

When and How to Make Changes

The election you make when you enroll in an FSA remains in effect for the entire calendar year. The only times you may change your elections—either begin, increase, decrease or stop contributions to an FSA—are:

- during open enrollment for the following calendar year;
- when you have a Change in Status Event in the current calendar year. (See “When You Have a Change in Status Event”)

To modify your FSA election when you have a Change in Status Event, you must notify the Employee Benefits Department of the change within 31 days of the date of the Change in Status Event. The change must be consistent with and resulting from the Change in Status Event.

When Participation Begins

The date your FSA begins depends on when you enroll:

- If you enroll in an FSA when you first become eligible for benefits, your FSA begins on the day your benefits begin and continues through the end of the calendar year.
- If you enroll in an FSA because of a Change in Status Event, your FSA becomes effective on the first of the month following your Change in Status Event and continues through the end of the calendar year.
- When you enroll in an FSA online during the annual open enrollment, your FSA begins on Jan. 1 of the following year and continues through the end of that calendar year.

When Participation Ends

Your participation in an FSA ends:

- On December 31, unless you complete a Benefit Election Form during open enrollment and make an FSA election for the following year;
- If you take a leave of absence without pay and do not continue your benefits coverage; or
- If you leave employment with Coldwater Creek and do not continue your benefits coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act).

In any event, when your participation in the plan ends, you have 90 days from the date of termination to submit claims for reimbursement.

How to Continue Participation

This section provides you with information on continuing participation in your health care and/or dependent care FSAs when you:

- leave employment with Coldwater Creek;
- go on a leave of absence under the Family Medical and Leave Act (FMLA); or
- go on an unpaid leave of absence.

Continuing Contributions When You Leave Employment

When you leave employment with Coldwater Creek, you may continue contributing to your health care FSA account and requesting reimbursements through the end of the calendar year as long as you elect to continue the FSA under COBRA. You have until March 31 of the following year to submit reimbursement requests for expenses incurred during the previous calendar year while under COBRA.

When you leave employment but don't continue your health care FSA under COBRA, your participation in your FSA ends the day you leave employment. You have 90 days following the date of termination to submit reimbursement requests for expenses incurred through the date you left employment with Coldwater Creek.

Your participation in your dependent care FSA ends the day you leave employment with Coldwater Creek. You have until March 31 of the following year to submit reimbursement requests for expenses incurred through the date you left employment.

Continuing Contributions Under FMLA

If you go on leave of absence under the Family Medical Leave Act (FMLA), you may continue your contributions to your health care and/or dependent care FSAs either pre-tax through payroll deduction if you are on paid status or after-tax if you are on unpaid status.

Continuing Contributions While on an Unpaid Leave of Absence

If you go on an unpaid leave of absence, your contributions to your health care and/or dependent care FSAs cease. Upon your return to work in a paid status, your contributions will resume, provided your paycheck is large enough for the remaining deductions.

Note that dependent care expenses incurred while you are on leave will not qualify for reimbursement under the dependent care FSA.

An Overview of FSAs

To make the most of your participation in an FSA, you need to know some things about them.

Tax Savings

FSA's allow you to benefit from pre-tax savings while setting aside funds for health care expenses or dependent care expenses, or both.

Health Care and Dependent Care FSA's Don't Mix

Health care and dependent care FSA's are separate accounts. The funds you allocate for one cannot be used for the other, and you cannot transfer dollars between accounts.

Health Care FSA Savings

The IRS allows you to take a federal income tax deduction for certain eligible health care expenses if they exceed 7.5% of your adjusted gross income, or instead you may set aside from a minimum of \$260 to a maximum of \$5,000 in pretax dollars to pay for these same expenses from a health care FSA. For most people, the health care FSA makes the most sense, but you should consult a tax advisor to be sure.

Dependent Care FSA Savings

If you work full-time or part-time and have children, a disabled spouse or another disabled dependent and use dependent care services regularly, you may take an income tax credit for your dependent care expenses, or instead you may set aside pretax dollars to pay for these same expenses from a dependent care FSA.

The minimum you may contribute to a dependent care FSA is \$260 per calendar year. The maximum you may contribute depends on your family situation, but the amount may not exceed \$5,000. If more than one of the following situations applies to you, your maximum contribution is the lesser of the two:

- If you are a working single parent, you may contribute up to \$5,000 per calendar year;
- If you are married and filing a joint income tax return, you may contribute up to \$5,000 per calendar year; if your spouse also has access to a dependent care FSA, your combined limit is \$5,000;
- If you are married and filing separate income tax returns, you may contribute up to \$2,500 per calendar year;
- If you are married and your spouse earns less than \$5,000, you may contribute up to the amount of your spouse's annual income.

For the federal tax credit, you may claim up to \$3,000 a calendar year for one dependent, or up to \$6,000 a calendar year for two or more dependents.

To determine whether the dependent care FSA or the federal tax credit, or a combination of both is best for you, you should consult a tax advisor.

Estimating Expenses

It is very important that you estimate your expenses as accurately as possible when deciding upon your contribution amounts for a health care FSA or a dependent care FSA, or both.

Because dependent care expenses are likely to be more predictable than health care expenses, it is usually easier to estimate the amount you may need to contribute to a dependent care FSA for a calendar year.

Because health care expenses are less predictable and all eligible expenses for you, your spouse and your eligible dependents are reimbursable from your health care FSA, you may find the following worksheet useful in helping you decide on your contribution amount for a health care FSA. Complete the worksheet to estimate eligible health care expenses not covered by your other benefits.

Making Contributions

When you enroll in a health care FSA during open enrollment, you begin making contributions to your account every paycheck through payroll deduction over the next calendar year.

If you are paid every other week, for example, the amount deducted is calculated by dividing your annual election by 26 pay periods. If you elected to contribute the maximum \$5,000 amount to your FSA during open enrollment, you would see a deduction of \$192.31 per paycheck throughout the year.

Highly Compensated Employees

Coldwater Creek reserves the right to make any adjustments necessary to highly compensated employee (annual salary of \$100,000 or greater) elections under the health care FSA as needed to pass any required discrimination testing.

Midyear Enrollments

When you enroll in a health care FSA midyear as a newly benefit-eligible employee or as a result of a Change in Status Event, you begin making contributions to your account through payroll deduction for the remainder of the calendar year. The amount deducted is calculated by dividing your election by the number of remaining pay periods. For example, if you elected to contribute the maximum \$5,000 amount to your FSA with 16 pay periods remaining in the calendar year, you would see a deduction of \$312.50 per paycheck for the remainder of the year.

Knowing What's Covered and What's Not

You may use a health care FSA to reimburse expenses for yourself and any dependent who qualifies for coverage under your benefit plans. However, Internal Revenue Code Section 152 generally prohibits use of a health care FSA to reimburse expenses for a domestic partner and domestic partner's children. You may wish to refer to IRS Publication 17 or consult a tax advisor.

Internal Revenue Code Section 152 also allows you to get reimbursed for expenses for:

- Any "qualified child," who is related to you and is 18 or younger in age as of the close of the calendar year (unless the child is a student, in which case he/she must be 23 years or younger in age as of the close of the calendar year) and who resides with you for more than half the year;
- Any "qualified relative," such as a child, grandchild, stepchild, brother, sister, stepbrother, stepsister, parent, grandparent, stepparent, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law or sister-in-law, who receives more than half his/her support from you during the calendar year;
- Any person not related to you but who lives with you as a member of your household, receives more than half his/her support from you during the calendar/plan year and is not the "qualified child" of another person.

Note that your domestic partner's child will generally qualify as the tax dependent of your domestic partner. Under the requirements above, this would exclude them from qualification as your tax dependent.

If you get reimbursed for expenses from a health care FSA for any dependents other than your spouse or dependent children, you may be required to provide an affidavit certifying them as eligible dependents based on the criteria described above.

Covered Expenses

Here is a partial list of health care expenses eligible for reimbursement through a health care FSA. If you have any questions on the eligibility of expenses, be sure to consult your tax advisor, IRS Publication 502, or the third-party administrator. The IRS publication references insurance premiums and long-term care insurance as eligible deductible expenses on an individual tax return, but they are not eligible for health care FSA reimbursement.

- Acupuncture
- Ambulance
- Artificial limbs
- Birth control pills, condoms, spermicides, pregnancy/ovulation kits
- Braille books and magazines
- Car controls for a disabled person
- Care for a mentally disabled child
- Chiropractor fees
- Christian Science practitioner fees
- Coinsurance/copays
- Contact lenses and contact cleaning solutions
- Cosmetic procedures to correct a problem arising from a medical condition
- Crutches
- Deductibles for medical, dental and vision plans
- Dental fees
- Dentures
- Diagnostic fees
- Disabled person's cost for special home
- Drug addiction treatment
- Eyeglasses
- Eye exams
- Fertility treatment
- Hearing aids and batteries
- Home improvements for medical reasons
- Hospital bills
- Hypnosis for treatment of an illness
- Insulin
- Laboratory fees
- Learning disability
- Life fee to retirement home for medical care
- Maternity care
- Naturopathic treatment
- Naturopathic remedies (if prescribed by physician for medical condition)
- New baby expenses for medical conditions
- Obstetrical services
- Operations
- Optometrist
- Orthodontics (non-cosmetic purposes)
- Orthopedic shoes
- Over-the-counter drugs used to treat/prevent illness/injury (limited)
- Oxygen
- Physician fees
- Prescription drugs
- Psychiatric care
- Psychologist fees
- Radial keratotomy
- Routine physicals
- Seeing-eye dog and its upkeep
- Skilled nurse fees (including board and Social Security taxes you pay)
- Smoking cessation
- Spa/pool equipment prescribed by physician and allowed by the IRS
- Special schools for mentally impaired or physically disabled person
- Telephone designed for hearing impaired person
- Television/hearing impaired equipment
- Therapeutic care for drug and alcohol addiction
- Therapy received as medical treatment
- Transportation expenses for medical purposes
- Tuition at special school for disabled person
- Tuition fee portion that goes for medical care
- Vaccines
- Weight loss programs (if prescribed by physician for medical condition)
- Well-baby and well-child care
- Wheelchair
- Wigs required for medical purposes
- X-rays

Expenses Not Covered

Here is a partial list of health care expenses not eligible for reimbursement through a health care FSA. If you have any questions on the eligibility of expenses, be sure to consult your tax advisor, IRS Publication 502, or the third-party administrator. (See *Contact Information*.)

- Cosmetic procedures for non-medical reasons
- Diaper services
- Divorce expenses (even if recommended by a physician)
- Domestic help fees (for services of a non-medical nature)
- General counseling (for example, family, marital or couple counseling)
- Health club programs, including fitness clubs and gyms
- Health insurance premiums
- Lens replacement insurance
- Long-term care insurance premiums and expenses
- Maternity clothes
- Parking fees
- Physical therapy treatments for general well-being
- Vitamins, supplements and remedies taken for general well-being

Filing a Claim

With a health care FSA, you may begin getting reimbursed from the FSA as soon as you incur eligible expenses in the FSA calendar year. You do not have to wait until you have sufficient funds in the account before you are reimbursed from the account.

How eligible expenses are reimbursed from a Health Care FSA depends on the type of expense you have: expense partially covered by health insurance, expense not covered by health insurance, or orthodontia expense.

For expenses partially covered by insurance, you file a claim with your health plan. When you receive your Explanation of Benefits (EOB), you see how much the plan paid and the remaining balance due. You then request reimbursement for the remaining balance.

Mail or fax a completed third-party administrator Reimbursement Request Form along with the following:

- An invoice from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided, *or*
- An Explanation of Benefits (EOB) from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost, *and*
- If necessary, because a service could be deemed cosmetic in nature, a written statement from your health care provider indicating that the service was medically necessary, accompanied by the invoice or EOB for the service.

The Third-Party Administrator's Reimbursement Request Form is available through the Employee Benefits Department. (See *Contact Information*.)

For expenses not covered by insurance, complete the Third-Party Administrator Reimbursement Request Form and attach your itemized receipt for the expenses. Receipts must show date of service, cost, service performed and provider of service. Canceled checks, credit card receipts or statements showing only "balance due" or "payment on account" cannot be accepted. Fax or mail the information to the third-party administrator.

For orthodontia services, a lump sum payment to an orthodontist is eligible for full reimbursement. To be reimbursed, you must provide documentation, such as a receipt of payment, claim form or payment coupon, and it must include the patient name, provider name, date of service and cost of service. A copy of your contract may be required. Monthly payments will be reimbursed based on the actual amount paid. Orthodontia payments may be reimbursed over multiple plan years.

When your health care FSA reimbursement request is received and approved, you are reimbursed for eligible expenses up to the maximum amount you elected, minus any previous reimbursements made during the calendar year.

If Reimbursement is Denied

If your claim for reimbursement is denied, the third-party administrator will notify you in writing within 30 days of your request, explaining the specific reasons for the denial, your right to appeal and your right to obtain free copies of documentation related to the decision. If matters beyond the third-party administrator's control require more time, the review period may be extended up to 15 days and you will be notified of the extension before the initial 30-day period ends. For more information see *Claim and Appeal Procedures*.

How the Dependent Care FSA Works

This section tells you the things you need to know about how a dependent care FSA works.

Making Contributions

To qualify for reimbursements from the dependent care FSA, you must be at work while your eligible dependents receive care. You must also meet one of the following eligibility requirements:

- You are a single parent;
- You have a working spouse;
- Your spouse is a full-time student at least five months during the calendar year while you are working;
- Your spouse is mentally or physically unable to care for him/herself;
- You are divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes.

When you enroll in a dependent care FSA during open enrollment, you begin making contributions to your account every paycheck through payroll deduction over the next calendar year.

If you are paid every other week, for example, the amount deducted is calculated by dividing your annual election by 26 pay periods. If you elected to contribute \$4,000 to your FSA during open enrollment, you would see a deduction of \$153.85 per paycheck throughout the year.

Highly Compensated Employees

Coldwater Creek reserves the right to make any adjustments necessary to highly compensated employee (annual salary of \$100,000 or greater) elections under the dependent care FSA as needed to pass any required discrimination testing.

Midyear Enrollments

When you enroll in a dependent care FSA midyear as a newly benefit-eligible employee or as a result of a Change in Status Event, you begin making contributions to your account through payroll deduction for the remainder of the calendar year. The amount deducted is calculated by dividing your election by the number of remaining pay periods. For example, if you elected to contribute the maximum \$5,000 amount to your FSA with 16 pay periods remaining in the calendar year, you would see a deduction of \$312.50 per paycheck for the remainder of the year.

Knowing What's Covered and What's Not

You may use a dependent care FSA to cover children, a spouse or another disabled dependent (such as your parents):

- A child under age 13 with whom you have a “specified relationship” and for whom you are entitled to claim a deduction on your federal tax return. For children of divorced or separated parents, only the parent with whom the child resides for more than half of the calendar year can claim the child an eligible dependent under this plan;
- Your dependent child of any age who is physically or mentally unable to care for himself/herself and who resides with you for more than half of the calendar year;
- Your spouse who is physically or mentally unable to care for himself/herself and who resides with you for more than half of the calendar year;
- An incapacitated dependent for whom you provide a majority of support and who resides with you for the entire calendar year.

A qualifying “specified relationship” to the taxpayer for a child under 13 is defined as a son, daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister or a descendant of any such individual. Legally adopted children and foster children are considered to be children of the taxpayer.

Covered Expenses

The following types of care are reimbursable from a dependent care FSA:

- Care provided inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes, or one of your children under age 19;
- A dependent care center or child care center (if the center cares for more than six children, it must comply with all applicable state and local regulations);
- A housekeeper, au pair or nanny whose services include, in part, providing care for a qualifying dependent;
- Adult care for an incapacitated spouse or parent; this includes only the day care expenses. Nursing/medical care does not qualify for reimbursement through a dependent care FSA, but may qualify under a health care FSA.

To qualify for reimbursement, you must provide your dependent care provider's tax ID number, Social Security number or license number on your federal tax return. If you fail to do so, your dependent care FSA reimbursements may be reclassified as taxable income by the IRS. You must complete IRS Form 2441 (“*Child and Dependent Care Expenses*”) when reporting taxes at the end of each calendar year.

You are responsible for making sure the expenses you submit for reimbursement are considered eligible expenses by the IRS. If you're not sure whether an expense is eligible, consult a tax advisor or contact the third-party administrator. (See *Contact Information*.)

Expenses Not Covered

Expenses not eligible for reimbursement through your dependent care FSA include:

- Books and supplies;
- Child support payments or child care if you are a noncustodial parent;
- Health care or educational tuition costs;
- Services provided by your dependent, your spouse's dependent or your child who is under age 19;
- Overnight camps and education, including kindergarten (but summer day camps are eligible).

However, if the cost of tuition and dependent care can be separated, the itemized cost of the dependent care is reimbursable. To be sure, you should consult a tax advisor.

Filing a Claim

To get reimbursed from a dependent care FSA, complete The Third-Party Administrator's Reimbursement Request Form and attach any appropriate receipts or have the dependent care provider sign the claim form instead of a receipt. Fax or mail the information to the third-party administrator. (See *Contact Information*.)

The third-Party Administrator's Reimbursement Request Form is available through the Employee Benefits Department (See *Contact Information*.)

If you submit a reimbursement request for an amount that is more than your account balance, you are reimbursed up to the amount you currently have in your account. When future contributions are made to your account, you automatically receive another reimbursement until your total claim amount has been reimbursed or you reach your election amount for the calendar year.

If Reimbursement is Denied

If your claim for reimbursement is denied, the third-party administrator will notify you in writing within 30 days of your request, explaining the specific reasons for the denial, your right to appeal and your right to obtain free copies of documentation related to the decision. If matters beyond the third-party administrator's control require more time, the review period may be extended up to 15 days and you'll be notified of the extension before the initial 30-day period ends. For more information see *Claim and Appeal Procedures*

Claim and Appeal Procedures

In the event you are denied a benefit under the Health Care FSA and Dependent Care FSA, the following claims review procedures have been established.

Step 1: *Notice is received from the third-party administrator.*

If your claim is denied, you will receive written notice from the third-party administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the third-party administrator, the third-party administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the third-party administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully.*

Once you have received your notice from the third-party administrator, review it carefully. The notice will contain:

- a) The reason(s) for the denial and the Plan provisions on which the denial is based;

- b) A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- c) A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- d) A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.*

If you do not agree with the decision of the third-party administrator and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from the third-party administrator.*

If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the third-party administrator.

Step 5: *Review your notice carefully.*

You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third-party administrator.

Step 6: *If you still disagree with the third-party administrator's decision, file a 2nd Level Appeal with the Plan Administrator.*

If you still do not agree with the third-party administrator's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the third-party administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- (Health Care FSA Only) Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures.

COBRA

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the Health Care FSA. These rules are intended to summarize the continuation rights set forth under federal law.

When Coverage May Be Continued

Only “Qualified Beneficiaries” are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A “Qualified Beneficiary” is the Participant, covered Spouse and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee’s Termination of employment or reduction in hours of employment	√	√	√
2. Divorce		√	
3. Child ceasing to be an eligible dependent			√
4. Death of the covered employee		√	√

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Health Care FSA upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health Care FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the Plan Administrator in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) date of the event (ii) the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date of the qualifying event and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g. divorce decree).

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Health Care FSA if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) and return it to the COBRA Administrator identified in the Plan Information Summary within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. Continuation coverage may end earlier for any of the following reasons:

- a) If the contribution for your continuation coverage is not paid on time or it is significantly insufficient;
- b) If you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- c) If you become entitled to Medicare; or
- d) If the employer no longer provides group health coverage to any of its employees.

ERISA Rights

As a participant in the Health Care FSA Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Dependents will have to pay for such coverage. You should review this summary for more information concerning your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the 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 obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers 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 plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

General Plan Information

1. Name, address, and telephone number of the Employer/Plan Sponsor:	Coldwater Creek One Coldwater Creek Drive Sandpoint, ID 83864 208-265-3965
2. Name, address, and telephone number of the Plan Administrator: Note: The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The agent for service of legal process is the Plan Administrator.	Coldwater Creek One Coldwater Creek Drive Sandpoint, ID 83864 208-265-3965
3. Employer's federal tax identification number:	82-0419266
4. Plan Number:	502
5. Effective Date of the Plan: Note: This is the date that the Plan was first established.	7/1/1996
6. Effective Date of this SPD:	01/01/09
7. Plan Year:	07/01/09 through 06/30/09
8. Flexible Spending Account Period of Election	01/01/09 through 12/31/09
8. Adopting Employers participating in the Plan:	1. Coldwater Creek, Inc. 2. Aspen Advertising 3. Coldwater Creek – The Spa Inc.
9. Third Party Administrator:	CONEXIS

Glossary

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 gives employees the ability to continue health insurance coverage after leaving employment.

Dependent Care FSA Expenses

These are expenses for dependent care that are eligible for reimbursement through a flexible spending account.

Federal Family and Medical Leave (FMLA)

This federal law allows employees to take unpaid leave due to illness or to care for a sick family member.

Federal Tax Credit

A federal tax credit is given to an individual or business as credit for a payment already made towards taxes owed.

FICA

The Federal Insurance Contributions Act is an employment tax imposed in an equal amount on employees and employers to fund federal programs for retirees, the disabled and children of deceased workers. The FICA taxes support Social Security and Medicare.

Health Care FSA Expenses

These are expenses for health care that are eligible for reimbursement through a flexible spending account.

Internal Revenue Code Section 125

This section of the Internal Revenue Code sets the rules and regulations governing the use of pre-tax payments for employer benefit plans, such as flexible spending accounts.

Internal Revenue Code Section 152

This section of the Internal Revenue Code sets the rules and regulations governing the definition and eligibility of dependents for various employer benefit plans, such as flexible spending accounts.

Contact Information

COLDWATER CREEK'S EMPLOYEE BENEFITS DEPARTMENT	Coldwater Creek One Coldwater Creek Drive Sandpoint, ID 83864 208-265-7079
THIRD-PARTY ADMINISTRATOR: CONEXIS	CONEXIS PO Box 227197 Dallas TX 75222 Participant Services Department 866-279-8385 Fax claims to: 888-866-3312