

Adoption Agreement

For: Topeka & Shawnee County Public Library Flexible Benefits Plan Ending December 31st

The undersigned Employer, by executing this Adoption Agreement, elects to amend the accompanying Flexible Benefits Plan by adopting said plan document in full. The Employer makes the following elections granted under the provisions of the plan.

1. The Name of the Employer: Topeka & Shawnee County Public Library

The Employer shall be the **Plan Sponsor** and **Plan Administrator**.

2. Effective Date:

This amended Flexible Benefits Plan shall be effective as of **January 1, 2014**

If amended and restated, the Plan was originally effective on **January 1, 1996**

3. Plan and Plan Year:

The Name of the Plan shall be the **Topeka & Shawnee County Public Library Cafeteria Plan** (the "Plan").

The initial Plan Year shall begin on January 1, 2014, and end on December 31, 2014.

Future Plan Years will be based on a full 12-month period beginning each January 1 and ending each December 31.

4. Plan Number: 501

5. Employer's Principal Office:

This Flexible Benefits Plan shall be governed under the laws of the:

State of Kansas

6. Eligible Employees:

(a) **All Employees shall be eligible to participate in the Plan, except:**

▪ **Under the Healthcare Flexible Spending Account, employees not eligible under Employer group health insurance plan; AND:**

❖ **Part-time Employees expected to work less than 20 hours per week.**

❖ Any Employee who is temporary or seasonal (working for the Employer less than 6 months of the year).

❖ Any Leased Employee, as well as any independent contractor, or other "statutory employee" who is not treated as a common law employee of the Employer for payroll purposes, regardless of any other court or administrative agency determination.

❖ Nonresident Aliens.

(b) N/A

7. Plan Entry Date/Waiting Period:

Employees eligible to participate may become Participants:

First of month after hire date (but subject to any shorter limitation period if mandated under applicable law).

8. Benefits:

The following Benefit Options shall be included in the Plan:

Healthcare Flexible Spending Account subject to an annual limit of \$ 2,500. (Not to exceed \$2,500, as indexed, for a 12-month Plan Year or prorated for a short Plan Year)

Dependent Care Assistance Program subject to the maximums contained in Section 7.9 of the Plan Document.

The Employer's Group Health Insurance (including health insurance, dental and vision insurance, AD&D, etc.).

Group Term Life Insurance.

Disability Insurance.

9. Contributions:

(If you are not adopting a Simple Cafeteria Plan, complete section (a) only. If you are adopting a Simple Cafeteria Plan, complete section (b) only.)

(a) The contributions for this Plan shall be:

Employee (Salary Redirection) contributions only;

(b) N/A

10. Claims Extension Period

The Plan shall be subject to the terms and conditions of Section 15.16 Claims Extension Period.

The Dependent Care Program shall be subject to the terms and conditions of Section 15.16 Claims Extension Period.

11. Carryover Provision

The Healthcare Flexible Spending Account shall not be subject to the terms and conditions of Section 15.17 Carryover Provision.

12. N/A (Expense allocation and Order of Benefits Payments if the Employer sponsors a Limited-Purpose Healthcare Spending Account)

13. N/A (Rollovers of IRAs to HSA Accounts)

14. N/A (Payment of HSA Medical Expenses During Claim Extension Period)

15. Affiliated Employers:

The following Employers have adopted this Plan:

16. Authorized Signatures:

Date _____
Company Name

By _____
Authorized Signature

Date _____
Affiliated Employer

By _____
Authorized Signature

Date _____
Affiliated Employer

By _____
Authorized Signature

Date _____
Affiliated Employer

By _____
Authorized Signature

Date _____
Affiliated Employer

By _____
Authorized Signature

Flexible Benefits Plan Document

**As Amended and Restated for
For: Topeka & Shawnee County Public Library
Flexible Benefits Plan
Ending December 31st**

Section 125 Cafeteria Plan	Pages 1 – 33
Section 132 Tax-free Transportation Program N/A	Pages 34 – 37
Section 223 Health Savings Accounts N/A	Pages 38 – 43
General Plan Provisions	Pages 43 – 58

Flexible Benefits Plan

Plan Document

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FLEXIBLE BENEFITS PLAN

INTRODUCTION

The Plan Sponsor designated in the Employer's Adoption Agreement (hereinafter referred to as the "Employer") hereby establishes a Flexible Benefits Plan (the "Plan") for its eligible Employees and for Eligible Employees of adopting Affiliated Employers. Its purpose is to reward them by providing Benefits for those Employees who shall qualify hereunder and their Dependents and Spouses. The concept of this Plan is to allow employees to choose among different types of Benefits based on their own particular goals, desires, and needs and to reimburse the Eligible Employees of the Employer for allowable expenses incurred by them, their Spouses, and Dependents. The Plan shall be known as a "Flexible Benefits Plan" (hereinafter referred to as the "Plan") and shall otherwise be referred to by the Plan Name provided within the Employer's completed Adoption Agreement.

The intention of the Employer is that, wherever appropriate, portions of the Plan shall qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the Benefits which an Employee elects to receive under such portions of the Plan be includable or excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended. If the Employer has elected in the Employer's Adoption Agreement to adopt a "Simple Cafeteria Plan," the intention of the Employer is that the Plan shall also qualify as a "Simple Cafeteria Plan" within the meaning of Section 125(j) of the Internal Revenue Code of 1986, as amended. Other Plan provisions, including the Tax-Free Transportation Program are not intended to qualify under Section 125, but instead shall separately qualify under other applicable sections (e.g., the Tax-Free Transportation Program would qualify as a Section 132(f) pre-tax benefit for Eligible Employees). Each program is consolidated under this Plan due to the joint administrative processes relating to each program; however, for purposes of applicable provisions of Section 125, Section 132(f), Section 223, and other applicable Code provisions, each program shall be considered as a separate Plan for purposes of the Code, ERISA and other applicable Regulations.

ARTICLE I

DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context:

1.1 "Administrator" or "Plan Administrator" means the Plan Sponsor identified in the Employer's Adoption Agreement. The Plan Sponsor may delegate any or all of its authority as the Administrator under this Plan to any third-party, pursuant to the terms of this Plan and in accordance with the terms of any applicable Service Agreement.

1.2 "Affiliated Employer" means the Employer and any corporation identified in the Employer's Adoption Agreement which is a member of a controlled group of corporations (as defined in Code Section 414(b)), which includes the Employer; any trade or business (whether or not incorporated) that is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) that is a member of an affiliated service group (as defined in Code Section

414(m)), which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury Regulations under Code Section 414(o).

1.3 “Benefit” means any of the optional benefit choices selected by the Participant as outlined under Article IV below or as otherwise specified in the Employer’s Adoption Agreement.

1.4 “Carryover Provision” means the \$500 carryover of any amount remaining unused in the Healthcare Flexible Spending Account as of the end of any Plan Year, pursuant to Section 15.17.

1.5 “Claims Extension Period” means the period that ends on the 15th day of the third month immediately following the end of the most recent Plan Year, pursuant to Section 15.16.

1.6 “Code” means the Internal Revenue Code of 1986, as amended or replaced from time to time, and which shall also include any governing Regulations or applicable guidance thereunder.

1.7 “Compensation” means the total cash remuneration received by the Participant from the Employer during a Plan Year prior to any reductions pursuant to a Salary Redirection Agreement authorized hereunder. Compensation shall include overtime, commissions, and bonuses.

1.8 “Dependent” means any individual who is defined under an Insurance Contract or who is a Qualifying Child or Qualifying Relative who qualifies as a dependent under an Insurance Contract or under Code Section 152 (as modified by Code Section 105(b)), as applicable. A Dependent also includes an adult child of a Participant who as of the end of the calendar year has not attained age 27. A child for purposes of this Section 1.7 means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle’s Law.

1.9 “Effective Date” means the Effective Date specified in the Employer’s Adoption Agreement.

1.10 “Election Period” means the period immediately preceding the beginning of each Plan Year established by the Administrator for the election of Benefits and Salary Redirection, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee’s initial Election Period shall be determined pursuant to Section 5.1.

1.11 “Eligible Employee” means any Employee who has satisfied the eligibility requirements necessary to participate in the Plan as stated in the Employer’s Adoption Agreement, or as otherwise set forth herein.

1.12 “Employee” means any person who is employed by the Employer, but for all portions of the Plan other than provisions relating to the Health Savings Account Program, generally excludes any person who is employed as an independent contractor or any person who is considered self-employed under Code Section 401(c), as well as a greater than two percent (2%) shareholder in a Subchapter S corporation, as defined under Code Section 1372(b), a partner in a partnership or an owner or member of a limited liability company that elects partnership status on its tax return.

1.13 “Employer” means the Plan Sponsor and any Affiliated Employer which is listed on the Employer’s Adoption Agreement; provided, however, that the Plan Sponsor retains authority as Plan Administrator for all purposes under the Plan and retains sole authority to amend or terminate the Plan

in accordance with Article XIII, without the approval of any Affiliated Employer which has adopted the Plan.

1.14 “Employer Contribution” means the contributions as identified in the Employer’s Adoption Agreement made by the Employer pursuant to Section 3.1 to enable a Participant to purchase Benefits. These contributions shall be converted to Flexible Benefits Plan Dollars and allocated to the accounts established under the Plan pursuant to the Participants’ elections made under Article V and shall be reimbursed for the cost of eligible Benefits described under Article IV, as well as other amounts contributed or elected to be contributed by the Employee for their Health Savings Account.

1.15 “Entry Date” means the earlier of the Plan Effective Date or the date an Employee becomes entitled to participate in the Plan as specified in the Employer’s Adoption Agreement.

1.16 “ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.17 “Flexible Benefits Plan Dollars” means the amount available to Participants, pursuant to Article III, to purchase Benefits. Each dollar contributed to this Plan, through either Employer Contribution or Employee Salary Redirection, shall be converted into one Flexible Benefits Plan Dollar.

1.18 “Health Savings Account” means an account established and maintained by the Plan in accordance with Code Section 223(d) to which part of any Eligible Employee’s Flexible Benefits Plan Dollars may be allocated and from which all HSA Medical Expenses may be reimbursed or otherwise distributed as otherwise set forth herein.

1.19 “High-Deductible Health Plan” means the program of health insurance coverage that qualifies under Code Section 223(c)(2), with limits and coverages as elected under the Employer’s Adoption Agreement.

1.20 “Highly Compensated Employee” means, for the purposes of determining discrimination, an Employee described in Code Section 125 and the Treasury Regulations thereunder.

1.21 “Insurance Benefits” means the benefits provided under any applicable insurance program or policy included within the list of qualifying, nontaxable benefit programs that have been selected as part of the Employer’s Adoption Agreement.

1.22 “Insurance Contract” means any contract issued by an Insurer underwriting a Benefit.

1.23 “Insurance Premium Payment Plan” means the plan of Insurance Benefits selected within the Employer’s Adoption Agreement, which provides for the payment of Premium Expenses under this Plan.

1.24 “Insurer” means any insurance company that underwrites a Benefit under this Plan or, the Employer if the Benefit is self-funded and otherwise paid for out of the Employer’s general assets or paid for through a separate trust established by the Employer.

1.25 “Key Employee” means an employee defined in Code Section 416(I)(1) and the Treasury Regulations thereunder.

1.26 “Leased Employee” means any employee described under Code Section 414(n)(2).

1.27 “Participant” means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.28 “Plan” means this instrument, including all amendments and attachments thereto.

1.29 “Plan Year” means the 12-month period designated in the Employer’s Adoption Agreement. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant’s date of entry and ending on the last day of such Plan Year.

1.30 “Premium Expenses” or “Premiums” means the Participant’s cost for the Insurance Benefits described in the Employer’s Adoption Agreement.

1.31 “Qualifying Child” means an individual who, unless otherwise described under Code Section 152(b):

- Is a child (as defined under Code Section 152(f)(1)) of the Employee, or a dependent of such child, or a brother, sister, stepbrother or stepsister of the Employee, or a descendent of any such relative;
- Who has the same principal residence, if allowed under local law, as the Employee for more than one-half of the current taxable year;
- Is under the age of 19 as of the end of the Plan Year in which the Employee was eligible under this Plan, or is under the age of 24 when covered as a full time student (as defined under Code Section 152(f)(2)), after consideration of Code Section 152(c)(3) as applicable; and
- Has not provided over one-half of his or her own support during the current Plan Year.

1.32 “Qualifying Relative” means an individual who, unless otherwise described under Code Section 152(d) or (e):

- Is a child (as defined under Code Section 152(f)(1)), or descendant of a child, or a brother, sister, stepbrother, stepsister, father, mother or any of their ancestors, or any other relative as described under Code Section 152(d)(2), including an individual who has the same principal residence as the Employee and who is a member of the Employee’s household;
- Has (with the exception of certain handicapped dependents described under Code Section 152(d)(4)) gross income for the Plan Year that is less than the allowable income exemption amount (as defined under Code Section 151(d) for that taxable year;
- For whom the Employee provides over one-half of the individual’s support for that calendar year; and
- Is not an otherwise Qualifying Child of the Employee for any portion of the Plan Year.

1.33 “Regulations” means either temporary, proposed or final regulations, as applicable, issued or released by the U.S. Department of Treasury, and any further or related guidance or interpretations, as well as such other federal or state regulations as otherwise applicable herein.

1.34 “Salary Redirection” means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Flexible Benefits Plan Dollars and

allocated to the accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.35 "Salary Redirection Agreement" means an agreement between the Participant and the Employer under which the Participant agrees to reduce his/her Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.36 "Spouse" means the legally married husband or wife of a Participant in accordance with applicable federal law, unless legally separated by court decree or otherwise specified by the Insurance Contract.

1.37 "Temporary or Seasonal Employee" means any employee who is either designated on the Employer's personnel records as a Temporary Employee or who is expected to work less than six (6) months per year with the Employer.

1.38 "Uniformed Services" means the Armed Forces, 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 of the United States in time of war or emergency.

All other defined terms in this Plan shall have the meanings specified in the various Articles of the Plan in which they appear.

ARTICLE II

PARTICIPATION

2.1 ELIGIBILITY

Any Employee of the Employer and its Affiliates who meets the eligibility requirements specified in the Employer's Adoption Agreement becomes an Eligible Employee and who executes a written election to participate shall be eligible to participate in the Plan on the date he/she has satisfied any applicable waiting period(s) specified in the Employer's Adoption Agreement (or the Effective Date of the Plan, if later) or any other eligibility criteria set forth herein. The eligibility and entry dates for the Health Care Flexible Spending Accounts must not be less than that of the underlying Affordable Care Act-Compliant employer-sponsored group health coverage.

Except as otherwise provided in any applicable Benefit Plans or insurance policies, former Participants who are rehired within 30 days or less of the date of termination of employment will be reinstated with the same election(s) such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, the individual may make a new election.

2.2 EFFECTIVE DATE OF PARTICIPATION

Any Employee who is eligible under Section 2.1 may become a Participant effective as of the first day of the month coinciding with or next following date requirements are met. Any Employee who does not elect to participate in the Plan on the date the Employee first becomes eligible may later elect to begin participating as of the first day of any Plan Year or an earlier Entry Date following a Change in Status pursuant to Section 5.4 hereof. If this is a restated Plan, each Employee who was a Participant in the Plan on the day prior to the restated Effective Date and is an Employee of an Employer on the Effective Date shall remain a Participant.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate and election of Benefits form, which the Administrator shall furnish to the Employee. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his/her Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to execute a Salary Redirection Agreement during the Election Period for which he/she wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's Effective Date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- a) Termination of employment, subject to the provisions of Section 2.7;
- b) The end of the Plan Year during which the individual became a limited Participant because of a change in employment status pursuant to Section 2.5;
- c) Death, subject to the provisions of Section 2.8; or
- d) The termination of this Plan, subject to the provisions of Section 12.2.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be an Eligible Employee because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. An employee will become a limited Participant if he/she meets the following three conditions:

- a) The Participant has taken an unpaid leave of absence from the Employer or has changed from full-time to part-time employment with the Employer; and

- b) The Participant elects under Section 3.1 to reduce his/her Salary Redirection to \$0 as a result of the change in employment status or classification; and
- c) Upon return to employment after a leave of absence or return to full-time from part-time employment, the Participant re-elects under Section 5.1 to increase his/her Salary Redirection to the level that existed immediately before it was reduced to \$0 (or to some other level if on account of and consistent with a change in status).

If COBRA applies, the Participant, while on the unpaid leave or in part-time employment status, will be given the opportunity to continue his/her Insurance Plans and Healthcare Flexible Spending Account. Premiums for the Participant's Insurance Benefits, as well as any applicable Premiums for the Participant's Healthcare Flexible Spending Account, may continue to be paid on a pre-tax basis provided the Participant receives Compensation during the leave period. If, however, the Participant receives no Compensation during the leave period, the Participant may continue Benefits under the Plan through payment of all Premiums with after-tax dollars outside of the Plan. Regardless of how Premiums are paid (either pre-tax or after-tax), the Participant will remain a full Participant in the Plan provided all Premiums are paid within 30 days of any due date.

As a limited Participant, except as otherwise provided herein, no further Salary Redirection may be made on behalf of the Participant, and, except as otherwise provided herein, all further Benefit elections shall cease, subject to the limited Participant's right to continue coverage under any Insurance Contracts. However, any balances in the limited Participant's Dependent Care Assistance Account or Adoption Assistance Program may be used during such Plan Year to reimburse the limited Participant for any allowable employment-related dependent expenses or qualified adoption expenses incurred during the Plan Year, subject to any other terms and conditions that are applicable under Articles VII and VIII respectively herein.

Further, in accordance with Article VI, any balances in the limited Participant's Healthcare Flexible Spending Account may be used during such Plan Year to reimburse the limited Participant for any allowable medical expenses incurred during the portion of the Plan Year in which the Employee was a full Participant in the Plan, provided that any claims are submitted within the grace period. Lastly, a Health Savings Account Beneficiary may continue to request reimbursement for medical expenses incurred during the period of previous Eligibility, or may rollover such amounts to another Health Savings Account as set forth under Code Section 223 and Article X below.

Subject to the provisions of Section 2.6, if the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided he/she otherwise satisfies the participation requirements set forth in this Article II as if he/she were a new Employee and made an election in accordance with Section 5.1.

2.6 FAMILY AND MEDICAL LEAVE ACT OF 1993

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's Benefits under this Plan on the same terms and conditions as though he/she were still an active Employee (i.e., the Employer will continue to pay its share of the premium to the extent the Employee opts to continue his/her coverage). If the Employee opts to continue his/her coverage, the Employee may pay his/her share of the Premium through one of the following methods:

- a) **Prepayment.** Under the prepayment option, the Participant increases his/her Salary Redirection in an amount sufficient to cover the Premiums and other expenses that will come due during the FMLA leave.
- b) **Pay-as-you go.** With the pay-as-you-go option, the Participant shall continue to pay Premiums on a regular basis throughout the FMLA leave. If the Participant continues to receive a salary while on FMLA leave, the applicable Premiums are to be paid with pre-tax contributions as if they had not taken the leave. On the other hand, if the Participant's FMLA leave is unpaid, the Administrator provides the funding for necessary coverage during the FMLA period, but the Participant is required to reimburse the Employer at regular intervals with after-tax funds for the Premiums that come due during the leave.
- c) **Catch Up.** The Administrator provides the funding for necessary coverage during the leave and subsequently withholds "catch-up" amounts from the Employee's pay upon his/her return.

Upon return from such leave, that has been or is being paid for under one of the methods referred to above, the Employee will be permitted to re-enter the Plan on the same basis the Employee was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

However, for the Healthcare Flexible Spending Account, if the coverage terminates due to revocation of the Benefit due to nonpayment of contributions by the Participant, two options will be offered upon the Participant's return to work:

- d) **Proration.** The actual amounts contributed by the Participant would remain in effect for the duration of the Plan Year, but the expenses incurred by the Participant during the lapse in coverage period would not be reimbursable and the maximum contribution amount would be reduced proportionately for the time that the Participant was not paying Premiums.
- e) **Reinstatement.** The Participant may elect to reinstate the level of coverage in effect when the leave began, with applicable contribution amounts being made up for the remainder of the Plan Year. The maximum coverage level will remain in effect from the Participant's Election, but the Participant cannot submit claims for reimbursement that were incurred during the lapse in coverage period.

Furthermore, if a Participant goes on a qualifying paid leave under the FMLA, to the extent required by the FMLA, the Employee will continue coverage while on FMLA by the method normally used during any paid leave.

In all instances, a paid or unpaid leave under FMLA will be treated in the same manner and consistent with a non-FMLA paid or unpaid leave.

2.7 TERMINATION OF EMPLOYMENT

If a Participant terminates employment with the Employer for any reason other than death, his/her participation in the Plan shall be governed in accordance with the following:

- a) With regard to Benefits that are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which Premiums have already been paid.
- b) With regard to the Dependent Care Assistance Program, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment-related dependent care expense reimbursements for the remainder of the Plan Year in which termination occurs, provided the claims are submitted within the grace period. Reimbursement for such claims will be based on the level of the Participant's Dependent Care Assistance Account as of the date of termination.
- c) With regard to the Health Savings Account Program, the Participant may be able to take distribution of any remaining Health Savings Account (HSA) balance amounts, or roll over any unused HSA balances to another qualifying Health Savings Account, in accordance with the terms of such other plan and in compliance with Code Section 223.
- d) With regard to the Adoption Assistance Program, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for qualified adoption expense reimbursements for the remainder of the Plan Year in which termination occurs, provided the claims are submitted within the grace period. Reimbursement of such claims will be based on the level of the Participant's Adoption Assistance Account as of the date of termination.
- e) With regard to the Healthcare Flexible Spending Account, the Participant may be able to elect to continue participation in the Plan in accordance with final and proposed IRS Regulations and as further provided below:
 - 1) COBRA continuation coverage will not be offered to Healthcare Flexible Spending Account Participants under the following circumstances:
 - (a) The Healthcare Flexible Spending Account has a deficit at the time of the Qualifying Event (i.e., if, taking into account all claims submitted on or before the date of the Qualifying Event, the Qualified Beneficiary's remaining Healthcare Flexible Spending Account balance for the Plan Year is less than the maximum required COBRA Premiums for the rest of the year); and
 - (b) The Healthcare Flexible Spending Account is exempt from HIPAA. For purposes of these rules, the Healthcare Flexible Spending Account is exempt from HIPAA if a major medical plan is available in addition to the Healthcare Flexible Spending Account, and the Healthcare Flexible Spending Account benefit does not exceed two times the Salary Redirection or, if greater, the Salary Redirection plus \$500.
 - 2) The Participant can elect to continue participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year in which the Qualifying Event occurs if:

- (a) The Healthcare Flexible Spending Account is exempt from HIPAA, under the procedures set forth under subparagraph (1)(b) above; and
 - (b) For the Plan Year in which the Qualifying Event occurs, the maximum amount the Qualified Beneficiary could be required to pay for a full year of Healthcare Flexible Spending Account COBRA coverage equals or exceeds the maximum Benefit available to the Qualified Beneficiary for the Plan Year.
- 3) If the Healthcare Flexible Spending Account is exempt from HIPAA under the procedures set forth under subparagraph (1)(b) above, the Participant's ability to continue coverage under the Healthcare Flexible Spending Account shall cease as of the end of the Plan Year in which the Qualifying Event occurs;
- 4) If the Healthcare Flexible Spending Account is not exempt from HIPAA, the Participant shall have the ability to continue coverage under the Healthcare Flexible Spending Account under procedures and conditions set forth below.

For purposes of these rules, "Qualifying Event" means the occurrence of any of the following:

- a) Death of a Covered Employee;
- b) Termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment;
- c) Divorce or legal separation of a Covered Employee from the Employee's Spouse;
- d) A Covered Employee's becoming eligible to receive Medicare benefits under Title XVIII of the Social Security Act; or
- e) A Dependent child of a Covered Employee ceasing to be a Dependent.

A "Qualified Beneficiary" is any person who is, as of the day before a Qualifying Event, (i) an Employee of the Employer (including persons who are considered to be "employees" within Code Section 401(c), directors, and independent contractors) covered under a health plan offered under the Plan as of such day (such persons are typically referred to as "Covered Employees"); (ii) the Spouse of the Covered Employee; or (iii) a Dependent of the Covered Employee. A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (other than for gross misconduct) or a reduction of hours of the Covered Employee's employment. A child born or placed for adoption with the Covered Employee during continuation coverage will also be considered as a Qualified Beneficiary. A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment will also be treated as a Qualified Beneficiary for purposes of these rules.

The Plan Administrator will notify Healthcare Flexible Spending Account Participants as to their COBRA eligibility (if any). The Plan Administrator shall also notify Healthcare Flexible Spending Account Participants as to their HIPAA rights and responsibilities under Code Section 9801 (including applicable provisions pertaining to HIPAA certification, portability, creditable coverage, and special enrollment procedures) if the Plan is not exempt from HIPAA under Section 2.7(e)(2) above.

If the Participant elects to continue participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year in which such termination occurs, the Participant may continue to seek reimbursement from the Healthcare Flexible Spending Account. The Participant shall be required to make contributions to the account based on the elections made prior to the beginning of the Plan Year.

If the Participant does not elect to continue participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year in which such termination occurs, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for expenses incurred during the portion of the Plan Year preceding his/her date of termination, provided the claims are submitted within the grace period. In the event a Participant terminates participation in the Healthcare Flexible Spending Account during the Plan Year, if Salary Redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or Benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

2.8 DEATH OF A PARTICIPANT

If a Participant dies during any Plan Year and at the time of death he/she has not received the total reimbursements available for the Plan Year, the Participant's surviving Spouse, children, or legal representatives can continue to submit claims for expenses incurred during the Plan Year pursuant to COBRA provisions stated in Section 2.7. In addition, the Spouse or other qualifying legal representatives shall have other rights to the remaining Health Savings Account balance in accordance with Code Section 223(h)(8) and as directed under Section 10.13 below. A Participant may designate a specific Beneficiary for this purpose. If no such Beneficiary is specified, the Administrator may designate the Participant's Spouse, a Dependent, or a representative of his/her estate.

ARTICLE III

CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

If a Participant's Employer Contribution to this Plan is not sufficient to cover the cost of Benefits or Premium Expenses being provided and elected pursuant to Article IV, the Participant's Compensation will be reduced in an amount equal to the difference between the cost of Benefits he/she elected and the amount of Employer Contribution available to the Participant. Such reduction in Compensation shall be his/her Salary Redirection, which the Employer will use on behalf of the Participant, together with his/her Employer Contribution, to pay for the Benefits elected by the Participant. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's Entry Date up to and including the last day of the Plan Year. These contributions shall be converted to Flexible Benefits Plan Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election and/or Salary Redirection Agreement with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Employer Contribution and Salary Redirection to provide the Benefits elected by the affected Participants.

Any contributions made or withheld from an Employee's Compensation, pursuant to the Employee's signed Salary Redirection Agreement for the Healthcare Flexible Spending Account, Dependent Care Assistance Account, Adoption Assistance Account, Tax-free Transportation Program, or Health Savings Account shall be credited to such account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Healthcare Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirections are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 3.1.

ARTICLE IV

BENEFITS

4.1 BENEFIT OPTIONS

Upon becoming a Participant prior to each Plan Year, a Participant must allocate his/her Flexible Benefits Plan Dollars, and Salary Redirection amounts, if any, among the Plan of Benefit Options indicated in the Employer's Adoption Agreement.

4.2 HEALTHCARE FLEXIBLE SPENDING ACCOUNT BENEFIT

If selected as an available Benefit Option under the Employer's Adoption Agreement, each Participant may elect coverage under the Healthcare Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE ASSISTANCE PROGRAM BENEFIT

If selected as an available Benefit Option under the Employer's Adoption Agreement, each Participant may elect coverage under the Dependent Care Assistance Program option, in which case Article VII shall apply.

4.4 ADOPTION ASSISTANCE PROGRAM BENEFIT – N/A

4.5 INSURANCE BENEFIT

Each Participant may elect to be covered under the Employer's Insurance Contract(s) selected in the Employer's Adoption Agreement for the Participant, his/her Spouse, and his/her Dependents. The Employer may select suitable Insurance Contracts for use in providing his/her health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit. The rights and conditions with respect to the benefits payable from such Insurance Contract shall be determined therein, and such Insurance Contract shall be incorporated herein by reference.

4.6 CASH BENEFIT

To the extent that a Participant elects to have less than the maximum amount of his/her Compensation contributed as a pre-tax Contribution or after-tax Contribution hereunder, such amount not contributed to the Plan as an allowable pre-tax Benefit option shall be paid to the Participant in the form of regular Compensation that is subject to applicable withholding and other employment tax obligations.

If, before the end of the applicable Election Period but after choosing Benefit options, some of a Participant's Flexible Benefits Plan Dollar or Salary Redirection amounts are not applied toward available Benefits (other than Vacation Conversion), then such amounts not so applied shall be forfeited to the Plan or paid to the Participant as additional cash Compensation, subject to any applicable limitations, as determined by the Employer's Adoption Agreement.

With the exception of the applicable cost of any Insurance Premium that will be automatically paid for on a pre-tax basis through use of Flexible Benefits Plan Dollars, or as otherwise set forth under Section 3.1 above (unless the Participant elects otherwise), if a Participant fails to make any election of Benefit options or does not elect any Salary Redirections, such Participant shall be deemed to have chosen the Cash benefit as his/her sole Benefit option. Participants deemed to have chosen the Cash benefit as their sole Benefit option shall have their Participant Flexible Benefits Plan Dollars applied in the form of regular Compensation in such amount and in the manner specified in the Employer's Adoption Agreement.

4.7 NONDISCRIMINATION REQUIREMENTS

- a) It is the intent of this Plan to provide Benefits to a classification of employees that the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.
- b) It is the intent of this Plan not to provide Qualified Benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, "Qualified Benefits" do not include: 1) any separate payment of Insurance Premiums by the Employer that are not paid for through this Plan, or 2) any Benefits to Key Employees that (without regard to this paragraph) would be includable in gross income.
- c) If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or nontaxable Benefits in order to assure compliance with this Section. Any action taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or nontaxable Benefits, it shall be done in the following manner. First, the nontaxable Benefits of the affected Participant (either an Employee who is Highly Compensated or a Key Employee, whichever is applicable) who has elected the highest amount of nontaxable Benefits for the Plan Year shall have his/her nontaxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his/her nontaxable Benefits equals the nontaxable Benefits of the affected Participant who has elected the second highest amount of nontaxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among non-Insurance Benefits, and once all non-Insurance Benefits are expended, proportionately among delineated Benefits. Insurance contributions, which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.
- d) If the Employer has elected in the Employer's Adoption Agreement to adopt a "Simple Cafeteria Plan" within the meaning of Section 125(j) of the Internal Revenue Code of 1986, as amended, and the Employer satisfies the eligibility and contribution requirements for implementing such a plan, this Plan shall be treated as satisfying the nondiscrimination requirements set forth in this Section 4.7.

4.8 TAX-FREE TRANSPORTATION PROGRAM BENEFIT – N/A

4.9 HEALTH SAVINGS ACCOUNT PROGRAM BENEFIT – N/A

ARTICLE V

PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he/she elects to do so before his/her Effective Date of participation pursuant to Section 2.2, or for a newly eligible Employee, no more than 30 days after their date of hire. For any such newly eligible Employee, if coverage is effective as of the date of hire pursuant to Section 2.1 above, such Employee shall be eligible to participate retroactively as of their date of hire. Newly eligible Employee Election amounts will be collected on the first pay period on or after his/her election was received. However, if such employee does not complete an application to participate and Benefit election form and deliver it to the Administrator before such date, his/her Election Period shall extend 30 calendar days after such date, or for such further period as the Administrator shall determine and apply on a uniform and nondiscriminatory basis. However, any election during the extended 30-day election period pursuant to this Section 5.1 shall not be effective until the first pay period following the later of such Participant's Effective Date of participation pursuant to Section 2.2 or the date of the receipt of the election form by the Administrator, and shall be limited to the Benefit expenses incurred for the balance of the Plan Year for which the election is made.

5.2 SUBSEQUENT ANNUAL ELECTIONS

With the exception of an Insurance Benefit or a Tax-Free Transportation Program premium election that is made as of the initial enrollment in the Plan without being required to make a new annual election during the Election Period for each subsequent Plan Year and subject to the following conditions with respect to other Benefits that the Participant can provide for payment under this Plan, each Participant shall be given the opportunity to annually elect, on an election of Benefits form to be provided by the Administrator, which Benefit options he/she wishes to select and purchase with his/her Flexible Benefits Plan Dollars. Any such election shall be effective for any Benefit expenses incurred during the Plan Year, which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

- a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;
- b) A Participant may terminate participation in the Plan by notifying the Administrator in writing during the Election Period that he/she does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;

- c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, or until a change in status event pursuant to Section 5.4 would justify an earlier mid-year election change.

5.3 FAILURE TO ELECT

Any Participant failing to complete an election of Benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year for the Healthcare Reimbursement, Dependent Care Assistance, Adoption Assistance Benefit, and/or Health Savings Account. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year, until a change in status event pursuant to Section 5.4 would justify an earlier mid-year election change. Elections under the Insurance Benefit or Tax-free Transportation Program shall remain in effect for such subsequent Plan Year.

5.4 CHANGE OF ELECTIONS

- a) With the exception of any specific circumstances otherwise described below, any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, 1) a change in status occurs, and 2) the requested revocation and new election satisfy the consistency requirements in Section 5.5. Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For this purpose, a change in status includes the following events:
 - 1) **Legal Marital Status.** Events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation, or annulment;
 - 2) **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
 - 3) **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or returns from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the Plan, then that change constitutes a change in employment under this subsection. Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status;

- 4) **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements.** An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance;
 - 5) **Residency:** A change in the place of residence of the Participant, Spouse, or Dependent;
 - 6) **Special requirements** concerning the Family and Medical Leave Act (FMLA) and the Health Insurance Portability and Accountability Act (HIPAA); and
 - 7) **Other.** Such other events that the Administrator (in its sole discretion) determines to be consistent with and attributable to a change in status. Additional proof may be required by the Administrator to support any change of status election submitted by a Participant.
- b) The Participant may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f).
 - c) If the change in status is due to a change in the Participant's marital status, under item 1) above, or a change in employment status of the Participant's Spouse or covered Dependents under item 3) above, the Participant may elect to increase or decrease group-term life coverage and/or group disability coverage corresponding with that change in status.
 - d) In the event of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child:
 - 1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's Plan; or
 - 2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child and such coverage is actually provided.
 - e) A Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). Further, if the Participant or the Participant's Spouse or Dependent that has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.

- f) A Participant may make a prospective election change to add group health coverage for the Participant or the Participant's Spouse or Dependent if such individual(s) lose coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a medical care program of an Indian Tribal government (as defined in Code Section 7701 (a) (40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable benefit package option(s).

In addition, to the extent permitted under the Children's Health Insurance Program Reauthorization Act of 2009, an Eligible Employee may enroll and a Participant may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), in the event that either (i) the Employee or his Dependent is covered under a plan offered under Medicaid or a State Children's Health Insurance Program (SCHIP) established under Title XXI of the Social Security Act and such coverage is terminated as the result of a loss of eligibility, or (ii) the Employee or Dependent becomes eligible for a state premium assistance subsidy from a plan offered under Medicaid or through a SCHIP). In either case, the Employee must meet the 60 day notice requirements imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

- g) If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments; or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage; or drop coverage prospectively if there is no other benefit package option available that provides similar coverage. This Plan treats coverage by another employer, such as a Spouse's or Dependent's employer, as similar coverage.
- h) If the cost of a Benefit provided under the Plan decreases significantly during a Plan Year, the Administrator shall permit the affected Participants to either make corresponding changes in their payments; and employees who are otherwise eligible under the Plan may elect the benefit package option, subject to the terms and limitations of the benefit package option.
- i) If the coverage under a Benefit is significantly curtailed and such curtailment results in a loss of coverage, or ceases during a Plan Year, any affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another Plan with similar coverage or drop coverage prospectively if there is no other benefit package option available that provides similar coverage.
- j) If the coverage under a Benefit is significantly curtailed and such curtailment does not result in a loss of coverage, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another Plan with similar coverage.

- k) If, during the period of coverage, a new benefit package option or other coverage option is added (or an existing benefit package option or other coverage option is eliminated), or a significantly improved existing benefit package option is added, then the affected Participants and employees who are otherwise eligible under the Plan may elect the newly added or significantly improved option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
- l) A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's, or Dependent's employer if 1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's, or Dependent's employer permits its Participants to make a change; or 2) the cafeteria plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's, or Dependent's employer.
- m) A cost change is allowable in the Dependent Care Assistance Program only if the cost change is imposed by the dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8). A cost change is allowable in the Adoption Assistance Program if there is the commencement or termination of an adoption proceeding. However, a Participant shall not be permitted to change an election to the Healthcare Flexible Spending Account as a result of a cost or coverage change under this subsection.
- n) Generally, the termination of employment by a Participant shall not be considered a change in status. Therefore, upon termination, such Participant shall not be entitled to change existing Benefit elections. Rather, such termination shall constitute a revocation of all existing Benefit elections, except with regard to the Healthcare Flexible Spending Account, in which case the Participant's election shall be governed by Section 2.7.
- o) Notwithstanding any other provision of this Plan, the Administrator may 1) permit a Participant to revoke (and subsequently reinstate) his/her election of one or more Benefit coverages under the Plan and 2) adjust a Participant's Compensation redirection as a result of a revocation or reinstatement to the extent the Administrator deems necessary or appropriate to assure the Plan's compliance with the provisions of the Family and Medical Leave Act of 1993 and any Regulations pertaining thereto.

5.5 CONSISTENCY REQUIREMENT

- a) A Participant's requested revocation and new election will be consistent with a change in status 1) if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a Plan of the Employer or under a Plan maintained by the employer of the Participant's Spouse or Dependent, and 2) with respect to dependent care assistance, if the election change is on account of and corresponds with a change in status that affects expenses described in Code Section 129 (including employment-related expenses defined in Code Section 21(b)(2)). A change in status election is not consistent if the change in status is due to the Participant's divorce, annulment, or legal separation from a Spouse; the death of a Spouse or Dependent; or a Dependent ceases to satisfy the eligibility requirements for coverage, yet the Participant's

election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. Likewise, if the Participant, Spouse, or Dependent gains eligibility for coverage under a family member plan as a result of a change in marital status or a change in employment status, then a Participant's election under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

- b) Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage.

ARTICLE VI

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Healthcare Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury Regulations thereunder. Participants who elect to participate in this Healthcare Flexible Spending Account may submit claims for the reimbursement of medical expenses. All amounts reimbursed under this Healthcare Flexible Spending Account shall be periodically paid from amounts allocated to the Participant's Healthcare Flexible Spending Account. Periodic payments reimbursing Participants from the Healthcare Flexible Spending Account shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Flexible Benefits Plan, the terms below have the following meaning:

- a) **"Healthcare Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Flexible Benefits Plan Dollars may be allocated and from which all allowable medical expenses may be reimbursed.
- b) **"Healthcare Flexible Spending Account Plan"** means the Plan of Benefits contained in this Article, which provides for the reimbursement of eligible medical expenses incurred by a Participant or his/her Dependents. And includes a Limited-Purpose Healthcare Flexible Spending Account that reimburses only vision and dental expenses.
- c) **"Highly Compensated Employee"** means for the purpose of this Article and determining discrimination under Code Section 105(h) a Participant who is:
 - 1) One of the five highest paid officers;

- 2) A shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
 - 3) Among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).
- d) **“Incurred”** means a medical expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed for, charged for, or pays for the medical care.
 - e) **“Medical Expenses”** means any expense for medical care within the meaning of the term “medical care” or “medical expense” as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury Regulations thereunder, and not otherwise used by the Participant as a deduction in determining his/her tax liability under the Code. However, a Participant may not be reimbursed for the cost of other health coverage such as Premiums paid under plans maintained by the employer of the Participant’s Spouse or individual policies maintained by the Participant or his/her Spouse or Dependent. Furthermore, a Participant may not be reimbursed for “qualified long-term care services” as defined under Code Section 7702B.

A participant may not be reimbursed for the cost of any medicine or drug that is not “prescribed” within the meaning of Code Section 106(f) or is not insulin.

- f) The definitions in Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Healthcare Flexible Spending Account.

6.3 FORFEITURES

The amount in the Healthcare Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 11.2.

6.4 LIMITATION ON ALLOCATIONS

- a) Notwithstanding any provision contained in this Healthcare Flexible Spending Account to the contrary, the maximum amount, which may be allocated by a Participant in or on account of any Plan Year to this Account, is prescribed in the Employer’s Adoption Agreement.
- b) **Cost of Living Adjustment.** In not event shall the amount of salary redirections on the Healthcare Flexible Spending Account exceed \$2,500 as indexed in accordance with Code Section 125(i)(2).
- c) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), or (m), relating to controlled groups and affiliated service groups, are treated a single employer for purposes of the \$2,500 limit.

- d) **Claims Extension Period and Carryover Provision.** Payment of expenses from a previous year in the first months of the next Plan Year, the \$2,500 limit applies to the Plan Year including the Claims Extension Period and Carryover provision and shall not affect the limit for the next Plan Year.

6.5 NONDISCRIMINATION REQUIREMENTS

- a) It is the intent of this Healthcare Flexible Spending Account not to discriminate in violation of the Code and the Treasury Regulations thereunder.
- b) If the Administrator deems it necessary to avoid discrimination under this Healthcare Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Healthcare Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Sections 105 or 125 that elected to contribute the highest amount of the account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the account equals the amount designated for the account by the next member of the group in whose favor discrimination may not occur pursuant to Code Sections 105 or 125 who has elected the second highest contribution to the Healthcare Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions, which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph, shall be forfeited and credited to the benefit plan surplus.
- c) If the Employer has elected in the Employer's Adoption Agreement to adopt a "Simple Cafeteria Plan" within the meaning of Section 125(j) of the Internal Revenue Code of 1986, as amended, and the Employer satisfies the eligibility and contribution requirements for implementing such a plan, this Plan shall be treated as satisfying the nondiscrimination requirements set forth in this Section 6.5.

6.6 COORDINATION WITH FLEXIBLE BENEFITS PLAN

All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Healthcare Flexible Spending Account. The enrollment and termination of participation under the Flexible Benefits Plan overall shall constitute enrollment and termination of participation under this Healthcare Flexible Spending Account Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Flexible Benefits Plan overall.

6.7 HEALTHCARE FLEXIBLE SPENDING ACCOUNT CLAIMS

- a) All Medical Expenses incurred by a Participant shall be reimbursed during the Plan Year subject to Sections 2.5 through 2.8, even though the submission of such a claim occurs after his/her participation hereunder ceases; but provided that the medical expenses were incurred during the applicable Plan Year.
- b) The Administrator shall direct the reimbursement to each eligible Participant for all allowable medical expenses, up to a maximum of the amount designated by the Participant for the Healthcare Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Flexible Benefits Plan Dollars which have been allocated to the account at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any healthcare plan covering the Participant and/or the Participant's Spouse or Dependents.
- c) Claims for the reimbursement of medical expenses incurred in any Plan Year shall be paid within 30 days after receipt by the Administrator; provided however, that if a Participant fails to submit a claim within the 90-day period immediately following the end of the Plan Year or the 90-day period immediately following a Participant's date of termination, those medical expense claims shall not be considered for reimbursement by the Administrator.
- d) Notwithstanding anything in this Section to the contrary, Medical Expenses incurred during the Claims Extension Period, up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Claims Extension Period relates, if selected in the Employer's Adoption Agreement.
- e) Notwithstanding anything in this Section to the contrary, Medical Expenses incurred within the 90-day period immediately following the end of the Plan Year shall be available for reimbursement from the previous Plan Year's leftover funds as prescribed in the Carryover Provision, if selected in the Employer's Adoption Agreement.

Unless payment arrangements are as directed within this paragraph or as otherwise specified below, reimbursement payments under this Plan shall be made directly to the Participant. However, at the Administrator's discretion, payments may also be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt for the service. The application shall include a written statement from an independent third party stating that the medical expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the medical expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Healthcare Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such statements and applications.

ARTICLE VII

DEPENDENT CARE ASSISTANCE PROGRAM

7.1 ESTABLISHMENT OF PROGRAM

This Dependent Care Assistance Program is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of employment-related dependent care expenses. All amounts reimbursed under this Dependent Care Assistance Program shall be periodically paid from amounts allocated to the Participant's Dependent Care Assistance Account.

7.2 DEFINITIONS

For the purposes of this Article and the Flexible Benefits Plan, the terms below shall have the following meaning:

- a) **“Dependent Care Assistance Account”** means the account established for a Participant pursuant to this Plan to which part of their Flexible Benefits Plan Dollars may be allocated and from which all employment-related dependent care expenses of the Participant may be reimbursed.
- b) **“Dependent Care Assistance Program”** means the program of Benefits contained in this Article, which provides for the reimbursement of eligible expenses for the care of the Qualifying Dependents of Participants.
- c) **“Earned Income”** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.
- d) **“Employment-Related Dependent Care Expenses”** means the amounts paid for expenses of a Participant for those services, which if paid by the Participant, would be considered employment-related expenses under Code Section 21(b)(2).

Generally, they shall include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there is one or more Qualifying Dependents with respect to such Participant. The determination of whether an amount qualifies as an employment-related dependent care expense shall be made subject to the following rules:

- 1) If such amounts are paid for expenses incurred outside of the Participant's household, they shall constitute employment-related dependent care expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(f)(1) (or deemed to be, pursuant to Section 7.2(f)(3)), or for a Qualifying Dependent as defined in Section 7.2(f)(2) (or deemed to be, pursuant to Section 7.2(f)(3)) who regularly spends at least 8 hours per day in the Participant's household;

- 2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at the facility, the facility must comply with all applicable State and local laws and regulations, including licensing requirements, if any; and
 - 3) Employment-related dependent care expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a dependent of such Participant or such Participant's Spouse.
- e) **"Highly Compensated Employee"** means an Employee who is a Highly Compensated Employee within the meaning of Code Section 414(q) and the Treasury Regulations thereunder.
- f) **"Qualifying Dependent"** means, for Dependent Care Assistance Program purposes,
- 1) A Dependent (as defined under Code Section 152(a)(1) who is under the age of 13;
 - 2) A Qualifying Child, a Qualifying Relative or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of residence as the Participant for more than one-half of year; or
 - 3) A Dependent that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).
- g) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Assistance Program.

7.3 DEPENDENT CARE ASSISTANCE ACCOUNTS

The Administrator shall establish a Dependent Care Assistance Account for each Participant who elects to apply Flexible Benefits Plan Dollars to Dependent Care Assistance Program Benefits.

7.4 INCREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be increased each pay period by the portion of Flexible Benefits Plan Dollars that he/she has elected to apply toward his/her Dependent Care Assistance Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be reduced by the amount of any employer-related dependent care expense reimbursements incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE ASSISTANCE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Assistance Account, a Participant who incurs employment-related dependent care expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he/she is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

By February 1 of each calendar year, the Employer shall furnish to each Employee who was a Participant and received Benefits under Section 7.6 during the prior calendar year, a statement of all such Benefits paid to or on behalf of such Participant during the prior calendar year.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Assistance Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 11.2.

7.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Assistance Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or (\$5,000 (\$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)) or such lesser or greater amount as determined by the Department of Treasury.

7.10 NONDISCRIMINATION REQUIREMENTS

- a) It is the intent of this Dependent Care Assistance Program that contributions or Benefits not discriminate in favor of Highly Compensated Employees or their Dependents, as prohibited by Code Section 129(d).
- b) It is the intent of this Dependent Care Assistance Program that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.
- c) If the Administrator deems it necessary to avoid discrimination or possible taxation to Highly Compensated Employees defined under Section 7.2(e) or to principal shareholders or owners as set forth in this Section, it may, but shall not be required to,

reject any elections or reduce contributions or nontaxable Benefits in order to assure compliance with this Section. Any action taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Assistance Account by the Highly Compensated Employee that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the Highly Compensated Employee who has elected the second highest contribution to the Dependent Care Assistance Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions, which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph, shall be forfeited.

- d) If the Employer has elected in the Employer's Adoption Agreement to adopt a "Simple Cafeteria Plan" within the meaning of Section 125(j) of the Internal Revenue Code of 1986, as amended, and the Employer satisfies the eligibility and contribution requirements for implementing such a plan, this Plan shall be treated as satisfying the nondiscrimination requirements set forth in this Section 7.10.

7.11 COORDINATION WITH FLEXIBLE BENEFITS PLAN

All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Dependent Care Assistance Program. The enrollment and termination of participation under the Flexible Benefits Plan shall constitute enrollment and termination of participation under this Dependent Care Assistance Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Flexible Benefits Plan.

7.12 DEPENDENT CARE ASSISTANCE PROGRAM CLAIMS

The Administrator shall direct the payment of all such Dependent Care Assistance claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, at the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for employment-related dependent care expenses submit a statement, which may contain some or all of the following information:

- a) The Dependent or Dependents for whom the services were performed;
- b) The nature of the services performed for the Participant, the cost of each he/she wishes reimbursement;
- c) The relationship, if any, of the person performing the services to the Participant;
- d) If the services are being performed by a child of the Participant, the age of the child;

- e) A statement as to where the services were performed;
- f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;
- g) If the services were being performed in a daycare center, a statement
 - 1) That the daycare center complies with all applicable laws and regulations of the state of residence,
 - 2) That the daycare center provides care for more than six individuals (other than individuals residing at the center), and
 - 3) Of the amount of fee paid to the provider.
- h) If the Participant is married, a statement containing the following:
 - 1) The Spouse's salary or wages if he/she is employed, or
 - 2) If the Participant's Spouse is not employed, that
 - (a) He/she is incapacitated, or
 - (b) He/she is a full-time student attending an educational institution and the months during the year which he/she attended such institution.
- i) If a Participant fails to submit a claim within the 90-day period immediately following the end of the Plan Year, the Administrator shall not consider those claims for reimbursement.
- j) All Dependent Care Assistance claims incurred by a Participant shall be reimbursed during the Plan Year subject to Sections 2.5 through 2.8 of the Plan, even though the submission of such a claim occurs after his/her participation hereunder ceases, provided that the Dependent Care Assistance Expenses were incurred during the applicable Plan Year.
- k) The Administrator shall direct the reimbursement to each eligible Participant for all allowable employment-related dependent care expenses, up to a maximum of the amount designated by the Participant for the Dependent Care Assistance Program for the Plan Year. Reimbursements shall be made available to the Participant throughout the year up to the level of Flexible Benefits Plan Dollars which have been allocated to the account at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any Dependent Care Assistance Plan covering the Participant and/or the Participant's Spouse or Dependents.
- l) Notwithstanding anything in this Section to the contrary, Dependent Care Expenses incurred during the Claims Extension Period, up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Claims Extension Period relates, if selected in the Employer's Adoption Agreement.

Furthermore, the Participant shall provide a written statement that the Dependent Care Assistance Expense has not been reimbursed or is not reimbursable under any other Dependent Care Assistance Plan coverage and, if reimbursed from the Dependent Care Assistance Program, such amount will not be claimed as a tax credit. The Administrator shall retain a file of all such applications.

ARTICLE VIII

ADOPTION ASSISTANCE PROGRAM

8.1 ESTABLISHMENT OF PROGRAM

This Adoption Assistance Program is intended to qualify as a program under Code Section 137 and shall be interpreted in a manner consistent with such Code Section. The purpose of this Program is to reimburse such Participants for all or a portion of the cost of adopting a child. Participants who elect to participate in this program may submit claims for the reimbursement of qualified adoption expenses. All amounts reimbursed under this Adoption Assistance Program shall be periodically paid from amounts allocated to the Participant's Adoption Assistance Account.

8.2 DEFINITIONS

For the purposes of this Article and the Flexible Benefits Plan, the terms below shall have the following meaning:

- a) **“Adoption Assistance Account”** means the account established for a Participant pursuant to this Plan to which part of their Flexible Benefits Plan Dollars may be allocated to the reimbursement of qualified adoption expenses.
- b) **“Adoption Assistance Program”** means the program of Benefits contained in this Article, which provides for the reimbursement of qualified adoption expenses in connection with the adoption of a child by Participants.
- c) **“Child with Special Needs”** means any child if:
 - 1) A State has determined that the child cannot or should not be returned to the home of his parents;
 - 2) Such State has determined that there exists, with respect to the child, a specific factor or condition (such as his/her ethnic background, age, or membership in a minority or sibling group; or the presence of factors such as handicaps) because of which it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance; and
 - 3) Such child is a citizen or resident of the United States (as defined in Section 217(h)(3)).

- d) **“Earned Income”** means earned income as defined under Code Section 32(c)(2), as amended, but excluding such amounts paid or incurred by the Employer for adoption assistance to the Participant.
- e) **“Eligible Child”** means any individual who has not attained the age of 18, or is physically or mentally incapable of caring for himself, including a child with special needs, as determined under Code Section 36C(d)(2).
- f) **“Foreign Adoption”** means the adoption of a child who is not a citizen or resident of the United States (as defined in Code Section 217(h)(3)) when the adoption proceedings begin.
- g) **“Highly Compensated Employee”** means an Employee who is a Highly Compensated Employee within the meaning of Code Section 414(q) and the Treasury Regulations thereunder.
- h) **“Modified Adjusted Gross Income (Modified AGI)”** means Adjusted Gross Income as defined in Code Section 62, with adjustments and application of Code Section 137(b)(3).
- i) **“Qualified Adoption Expenses”** means the amounts incurred for expenses of a Participant for those services, which if paid by the Participant would be considered qualified adoption expenses under Code Section 36C(d)(1). Generally, they shall include reasonable and necessary adoption fees, court costs, attorney fees, and other expenses that are:
 - 1) Directly related to, and the principal purpose of which is for, the legal adoption of an eligible child by the Participant;
 - 2) Not incurred in violation of State or Federal law or in carrying out any surrogate parenting arrangement;
 - 3) Not expenses in connection with the adoption by an individual of a child who is the child of such individual’s Spouse; and
 - 4) Not reimbursed under any other employer program or a credit allowance, as described under Code Section 36C, or otherwise.

The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Adoption Assistance Program.

8.3 ADOPTION ASSISTANCE ACCOUNTS

The Administrator shall establish an Adoption Assistance Account for each Participant who elects to apply Flexible Benefits Plan Dollars to Adoption Assistance Program Benefits.

8.4 INCREASES IN ADOPTION ASSISTANCE ACCOUNTS

A Participant's Adoption Assistance Account shall be increased each pay period by the portion of Flexible Benefits Plan Dollars that the Participant has elected to apply toward his/her Adoption Assistance Account pursuant to elections made under Article V hereof.

8.5 DECREASES IN ADOPTION ASSISTANCE ACCOUNTS

A Participant's Adoption Assistance Account shall be reduced by the amount of any qualified adoption expense reimbursements incurred on behalf of a Participant pursuant to Section 8.13 hereof.

8.6 ALLOWABLE ADOPTION ASSISTANCE REIMBURSEMENT

Subject to limitations contained in Sections 8.9 and 8.10 of this Program, and to the extent of the amount contained in the Participant's Adoption Assistance Account, a Participant who incurs qualified adoption expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he/she is a Participant.

8.7 ANNUAL STATEMENT OF BENEFITS

By February 1 of each calendar year, the Employer shall furnish to each Employee who was a Participant and received Benefits under Section 8.6 during the prior calendar year, a statement of all such Benefits paid to or on behalf of such Participant during the prior calendar year.

8.8 FORFEITURES

The amount in a Participant's Adoption Assistance Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 8.13 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 11.2.

8.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Adoption Assistance Account in or on account of any taxable year of the Participant shall not exceed \$13,190 in 2014 (as adjusted for inflation, in accordance with Code Section 137(f)) for each effort to adopt an Eligible Child. The amount is the maximum amount of qualified adoption expenses taken into account over all taxable years. Therefore, the \$13,190 must be reduced by the amount of qualified adoption expenses taken into account in previous taxable years for the same adoption effort. For purposes of the adoption of a Child with Special Needs, the \$13,190 limit shall be without regard to actual qualified adoption expenses. In the case of Foreign Adoption circumstances, qualifying adoption expenses shall not be excluded from income until the taxable year in which the adoption becomes final.

8.10 LIMITATION OF INCOME

Notwithstanding any provision contained in the Article to the contrary, if applicable, amounts paid from a Participant's Adoption Assistance Account in or on account of any taxable year of the Participant shall not only be limited, in accordance with the provisions of Section 8.9 above, but may also be reduced (but not below zero) by a percentage amount prescribed by Code Section 137(b), as amended, that increases in percentage reduction based on any increases in Modified Adjusted Gross Income (AGI) over the amounts specified under Code Section 137(b)(2).

8.11 NONDISCRIMINATION REQUIREMENTS

It is the intent of this Adoption Assistance Program that the Program shall benefit all Eligible Employees in a nondiscriminatory manner that is in accordance with Code Section 137(C)(2)(b). It is the intent of this Adoption Assistance Program that not more than 5 percent of the amounts paid or incurred by the employer for adoption assistance during the year may be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents) each of whom (on any day of the year) owns more than 5 percent of the stock or the capital or profits interest in the employer.

If the Administrator deems it necessary to avoid discrimination or possible taxation to Highly Compensated Employees defined under Section 8.2(g) or to principal shareholders or owners as set forth in this Section, it may, but shall not be required to, reject any elections or reduce contributions or nontaxable Benefits in order to assure compliance with this Section. Any action taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. Contributions, which are not utilized to provide Benefits to any Participant by virtue of any administrative action under this paragraph, shall be forfeited.

8.12 COORDINATION WITH FLEXIBLE BENEFITS PLAN

All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Adoption Assistance Program. The enrollment and termination of participation under the Flexible Benefits Plan shall constitute enrollment and termination of participation under this Adoption Assistance Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Flexible Benefits Plan.

8.13 ADOPTION ASSISTANCE PROGRAM CLAIMS

- a) With the exception of Foreign Adoption situations, all qualified adoption expenses incurred by a Participant shall be reimbursed during the Plan Year subject to Sections 2.5 through 2.8 of the Plan, even though the submission of such a claim occurs after his/her participation hereunder ceases, provided that the qualified adoption expenses were incurred during the applicable Plan Year.
- b) The Administrator shall direct the reimbursement to each eligible Participant for all allowable qualified adoption expenses, up to the lesser of the maximum of the amount designated by the Participant for the Adoption Assistance Account for the Plan Year, or the maximum \$13,190 for 2014 limit per child (as adjusted for inflation). Furthermore, a

Participant shall be entitled to reimbursements only for amounts in excess of any previous payments or other reimbursements previously made under this, or any other, Adoption Assistance Program covering the Participant and/or the Participant's Spouse or Dependents.

- c) Reimbursement payments under this Plan shall be made directly to the Participant. However, at the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt for the service. The application shall include a written statement from an independent third party stating that the qualified adoption expense has been incurred and the amount of such expense.
- d) If a Participant fails to submit a claim within the 90-day period immediately following the end of the Plan Year, the Administrator shall not consider those claims for reimbursement.
- e) The Participant shall provide a written statement that the qualified adoption expense has not been reimbursed or is not reimbursable under any other Adoption Assistance Plan coverage and, if reimbursed from the Adoption Assistance Account, such amount will not be claimed as a tax credit. The Administrator shall retain a file of all such applications.
- f) Notwithstanding anything in this Section to the contrary, Adoption Expenses incurred during the Claims Extension Period, up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Claims Extension Period relates, if selected in the Employer's Adoption Agreement.

ARTICLE IX

TAX-FREE TRANSPORTATION PROGRAM

9.1 ESTABLISHMENT OF PROGRAM

If elected as part of the Employer's Adoption Agreement, the Employer has made available this Tax-Free Transportation Program to provide tax-free transportation Benefits in lieu of otherwise taxable Compensation. It is intended that this Program comply with the requirements of Internal Revenue Code Section 132(f).

9.2 DEFINITIONS

For the purposes of this Article and the Flexible Benefits Plan, the terms below shall have the following meaning (to the extent not inconsistent, all other definitions identified under Article I shall be incorporated by reference):

- a) **"Commuter Highway Vehicle"** means any highway vehicle:
 - 1) Which has a seating capacity of at least six adults (not including the driver), and
 - 2) Of which at least 80% of the mileage use is reasonably expected to be used:
 - 3) For purposes of transporting Employees in connection with travel between their residences and their places of Employment, and
 - 4) On trips during which places the number of Employees transported for such purposes is, on average, at least half of the adult seating capacity of such vehicle (not including the driver).
- b) **"Commuter Highway Vehicle (Van Pool) Expenses"** means expenses incurred for transportation in a Commuter Highway Vehicle if such transportation is in connection with travel between the Employee's residence and place of Employment.
- c) **"Coverage Period"** means the monthly, quarterly, semi-annual, annual, or other period, designated on the Salary Redirection Agreement during which a Salary Redirection Agreement is in effect and irrevocable.
- d) **"Eligible transportation expenses"** means those qualified expenses incurred by the Employee to purchase or pay for Transit Pass Expenses, Commuter Vehicle Expenses, or Qualified Parking Expenses incurred for purposes of transportation between an Employee's residence and place of Employment.
- e) **"Program"** means the Employer's Tax-Free Transportation Program as set forth in its entirety in this document as may be amended from time to time.
- f) **"Program Year"** means the 12-month period beginning and ending on the dates specified in Item (f) of the Adoption Agreement - provided, however, that a period of less than 12 months may be a Program Year for the initial and final Program Year, and a

transition period to a different Program Year. The Program Year shall be the coverage period for the eligible transportation expenses provided under this Program. In the event a Participant commences participation during a Program Year, then the initial coverage period shall be that portion of the Program Year commencing on such Participant's date of entry and ending on the last day of such Program Year.

- g) **“Qualified Parking Expenses”** means the following parking expenses, unless such expenses are incurred for any parking on or near property used by the Employee for residential purposes:
- 1) Expenses incurred by an Employee to park his/her car on or near the business premises of the Employer; or
 - 2) Expenses incurred by an Employee to park his/her car on or near a location from which the Employee commutes to work:
 - (a) By mass transit facilities, whether or not publicly owned;
 - (b) By using the services of any person in the business of transporting persons for compensation or hire, if such transportation is provided in a Commuter Highway Vehicle, as defined in this Program;
 - (c) By Commuter Highway Vehicle; or
 - (d) By carpool (i.e., two or more individuals who commute together in a motor vehicle on a regular basis).
- h) **“Transit Pass Expenses”** means expenses incurred for any pass, token, fare card, voucher, or similar item entitling a person to transportation (or transportation at a reduced price) if such transportation is:
- 1) Provided by any mass transit facilities, whether or not publicly owned; or
 - 2) Provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver).

9.3 ELECTION OF BENEFITS

Eligible Employees may enter into a Salary Redirection Agreement with the Employer whereby the Employee agrees to reduce his/her unearned Compensation by the amount of his/her anticipated future eligible transportation expenses for the upcoming Coverage Period. The amount elected for reduction will be divided by the remaining payroll periods in the Coverage Period. The resulting per payroll period reduction amount will be deducted on a pre-tax basis from the Employee's Compensation per payroll period until such time as the Employee changes his/her election for an upcoming Coverage Period.

9.4 ACCOUNT

The Administrator will create and maintain a bookkeeping account on behalf of each Employee who enters into a Salary Redirection Agreement, which account will reflect the accumulated amount of Compensation that has been deducted on a pre-tax basis from the Employee's Compensation. When cash reimbursement is made to the Employee for his/her eligible transportation expenses, the balance of said account will be reduced by the amount of the reimbursement. The amount of any reimbursement shall not exceed the accumulated amount in said account at the time of the reimbursement, nor any of the following monthly limitations:

- a) Monthly Limitation for Qualified Parking Expenses. Reimbursements for Qualified Parking Expenses will not exceed the monthly value as set forth in Code Section 32(f)(2)(B), as adjusted for inflation;
- b) Monthly Limitation for Transit Pass Expenses and Commuter Highway Vehicle Expenses. Reimbursements for combined expenses for Transit Pass Expenses and Commuter Highway Vehicle Expenses will not exceed the monthly value as set forth in Code Section 132(f)(2)(A), as adjusted for inflation; and
- c) Special Rules for Transit Passes. A cash reimbursement may not be provided for an employee's mass transit expenses if a voucher (or similar item that may be exchanged only for a transit pass) is readily available to the Employer for direct distribution to Employees. A voucher (or similar item) is readily available if:
 - 1) The Employer can obtain the voucher on terms that are no less favorable than the terms available to an Employee directly, and
 - 2) The Employer does not incur a significant administrative cost in obtaining the voucher. An administrative cost will be determined to be "significant" if the Program Administrator (in its sole discretion) determines that the average administrative cost incurred by the Employer (excluding delivery charges of \$15 or less) is more than one percent (1.0%) of the average monthly value of the vouchers for a particular transit system (i.e., train, bus, subway).

9.5 TIME PERIOD FOR MAKING, MODIFYING, OR REVOKING A SALARY REDIRECTION AGREEMENT

A Salary Redirection Agreement must be made before the earlier of 1) the Coverage Period to which it relates; and 2) the receipt of eligible transportation expense Benefits to which it relates. Such election shall be effective for the first pay period after the Employer processes the change. Once a Salary Redirection Agreement is made, it cannot be changed during the Coverage Period to which it relates. Salary Redirection Agreements may only be changed for future Coverage Periods.

9.6 CARRYOVER OF UNUSED AMOUNT IN ACCOUNT

Any amount in the Employee's Tax-Free Transportation Program Account that has not been used to reimburse the Employee for eligible transportation expenses incurred prior to the end of the Coverage

Period to which the Employee's Salary Redirection Agreement applies will be carried over into future Coverage Periods.

9.7 TERMINATION OF AGREEMENT

The Employee's Salary Redirection Agreement shall terminate upon termination or any other discontinuation of employment. Amounts remaining in the Employee's Tax-Free Transportation Program Account will be forfeited.

9.8 EXPENSE SUBSTANTIATION

The Employee may request reimbursement for eligible transportation expenses by submitting in the manner and form approved by the Administrator a record of the expenses incurred, including the usage of established claim payment and substantiation processes set forth under Article XII. However, the Employee shall generally provide information showing that any eligible transportation expenses were in fact incurred by the Employee. The Employee generally must certify in writing the amount paid and the date of the expenses for which reimbursement is requested, as well as submit evidence of such payment (parking receipt, used transit pass, etc.). The information submitted by the Employee may vary depending on the facts and circumstances surrounding the expenses, including the method of payment and the particular transportation method used by the Employee.

9.9 REIMBURSEMENT OF EXPENSES

The Administrator will provide reimbursement of substantiated eligible transportation expenses on an administratively convenient periodic basis and will debit the Employee's Tax-Free Transportation Program Account accordingly, but under no circumstances will the Administrator provide reimbursement for any expense submitted more than 180 days after the date in which the eligible transportation expense was incurred.

ARTICLE X

HEALTH SAVINGS ACCOUNT PROGRAM

10.1 ESTABLISHMENT OF PROGRAM

This Health Savings Account Program (hereinafter the “HSA”) is intended to qualify as a program under Code Section 223 and shall be interpreted in a manner consistent with such Code Section. Eligible Individuals who elect to participate in this program may make contributions to the HSA if provided for under the Employer's Adoption Agreement and may submit claims for the reimbursement of eligible HSA Medical Expenses. All amounts reimbursed under this Health Savings Account Program shall be periodically paid from amounts allocated to the Account Beneficiary's Health Savings Account. If elected in the Employer's Adoption Agreement, the Employer shall also make contributions to the HSA as provided for herein, including any provisions related to allowable limits on annual contributions and applicable nondiscrimination standards.

10.2 ADDITIONAL DEFINITIONS

For the purposes of this Article and the Plan, the terms below shall have the following additional meaning from that otherwise provided under Article I:

- a) **“Account Beneficiary”** means a qualifying Participant on whose behalf the Health Savings Account has been established.
- b) **“Eligible Individual”** means an Eligible Employee or Dependent who:
 - 1) Is covered under a qualifying High-Deductible Health Plan, in accordance with requirements set forth under Code Section 223(c)(2), but which may also provide “preventive care,” which includes:
 - (a) Periodic health evaluations, including tests and diagnostic procedures ordered or in connection with routine examinations, such as annual physicals;
 - (b) Routine prenatal and well-child care;
 - (c) Child and adult immunizations;
 - (d) Tobacco-cessation programs;
 - (e) Obesity weight-loss programs;
 - (f) Certain screening services and other programs and services as approved by Code Section 223(c)(2)(C) and applicable Treasury Regulations and guidance information.

- 2) Is not an individual that may be claimed as a Dependent by another person for tax purposes, under Code Section 151; and
- 3) Is not covered under any other health plan, with the exception of any policy or program that only provides coverage for the following:
 - (a) Accidents;
 - (b) Disability;
 - (c) Dental;
 - (d) Vision;
 - (e) Long-term care;
 - (f) Or other “permitted insurance” defined under Code Section 223(c)(3), as otherwise amended from time to time, including insurance for a specified disease or illness.

Notwithstanding the above, an individual or his/her Dependents will no longer be considered as an “Eligible Individual” that is entitled to receive additional contributions of Flexible Benefits Plan Dollars to any Health Savings Account under this Plan when such individual becomes enrolled in Medicare Benefits under Title XVII of the Social Security Act. For purposes of this Section and an Employee's status as an “Eligible Individual”, the Plan shall only take into consideration an Employee's participation in a qualifying High-Deductible Health Plan during any applicable Claim Extension Period as otherwise provided for in the Employer's Adoption Agreement and as otherwise allowable under Code Section 223(c)(1)(iii).

- c) **“Health Savings Account Program”** means the program of Benefits contained in this Article, which provides for the payment or reimbursement of eligible expenses for qualifying HSA Medical Expenses of any Account Beneficiary or Beneficiaries.
- d) **“HSA Medical Expenses”** means, unless otherwise provided for under this Plan, the amounts paid by or for an Account Beneficiary for medical care (as defined under Code Section 213(d)) for such individual, his/her Spouse, or any other qualifying Dependent, but only to the extent not compensated by or paid for by insurance, or as otherwise described under Code Section 223(d)(2). HSA Medical Expenses shall also not include the cost of purchasing health insurance unless the purchase of such coverage is related to:
 - 1) Any health insurance paid for during any period of health continuation coverage required under Federal law (COBRA);
 - 2) Any qualifying long-term care Insurance Contract (defined under Code Section 7702B(b)(1));
 - 3) Any health plan coverage provided during any period in which an individual is receiving unemployment compensation under any Federal or State law;
 - 4) Any health insurance coverage (other than Medicare Supplemental Insurance Coverage, as defined under Section 1882 of the Social Security Act) provided

under Medicare to any Account Beneficiary who has attained the age specified in Section 1811 of the Social Security Act; or

- 5) Such other coverages as provided for under Code Section 223(d)(2)(C).
- e) **“Trustee”** means the designated Trustee (as defined under Code Section 223(d)(1)(B)) of any Trust established for qualifying Account Beneficiaries who elect to establish a Health Savings Account as set forth hereunder.

The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Savings Account Program.

10.3 HEALTH SAVINGS ACCOUNTS

The Administrator shall establish a Health Savings Account for each Account Beneficiary who elects to apply Flexible Benefits Plan Dollars, allowable IRA rollovers or Qualified HSA Distributions to Health Savings Account Program Benefits.

10.4 INCREASES IN HEALTH SAVINGS ACCOUNTS

An Account Beneficiary’s Health Savings Account shall be increased each pay period by the portion of Flexible Benefits Plan Dollars that he/she has elected to apply toward his/her Health Savings Account pursuant to elections made under Article V hereof, including consideration of any applicable Employer Contribution amounts. The Account Beneficiary’s Health Savings Account may also be increased by any rollover amounts that are accepted by this Plan from another qualifying Health Savings Account as otherwise provided for under the Employer’s Adoption Agreement, including through the receipt of allowable distributions from an Individual Retirement Account, or Qualified HSA Distributions if received within the period of time and manner set forth under applicable law or any Regulations thereunder. Periodic interest income or other investment earnings accumulations may also be credited to the balance of the Account Beneficiary’s Health Savings Account as directed by the Plan, any applicable Trust, the Employer’s Adoption Agreement, or other applicable law.

10.5 DECREASES IN HEALTH SAVINGS ACCOUNTS

An Account Beneficiary’s Health Savings Account shall be reduced by the amount of any HSA Medical Expenses reimbursements incurred on behalf of an Account Beneficiary pursuant to Section 10.12 hereof. The Account Beneficiary’s Health Savings Account may also be reduced by any depreciation in interest earnings or other investment accumulations, to the extent required by the Plan, any applicable Trust, the Employer’s Adoption Agreement or other applicable law. The Account Beneficiary’s Health Savings Account balance may also be reduced or eliminated by any other distribution made in accordance with Section 10.13 below.

10.6 ALLOWABLE HEALTH SAVINGS ACCOUNT REIMBURSEMENT

Subject to limitations contained in Section 10.9 of this Program, and to the extent of the amount contained in the Account Beneficiary's Health Savings Account, an Account Beneficiary who incurs HSA Medical Expenses shall be entitled to receive from the Employer reimbursement for the entire amount of such qualifying HSA Medical Expenses incurred during the Plan Year or portion thereof during which he/she is an Account Beneficiary.

10.7 ANNUAL STATEMENT OF BENEFITS

By February 1 of each calendar year, or as otherwise specified by the applicable HSA Trustee or Custodian if applicable, the Employer shall furnish to each Employee who was an Account Beneficiary and received benefits under Section 10.6 during the prior calendar year, a statement of all contributions made to the Health Savings Account as well as such benefits or other distributions paid to or on behalf of such Account Beneficiary during the prior calendar year.

10.8 UNUSED HEALTH SAVINGS ACCOUNT BALANCES

The amount in an Account Beneficiary's Health Savings Account as of the end of any Plan Year (and after the processing of all claims and authorized expenditures for such Plan Year pursuant to Section 10.12 hereof) shall be carried over and available for use in the subsequent Plan Year.

10.9 LIMITATION ON CONTRIBUTIONS

Notwithstanding any provision contained in this Article to the contrary, amounts contributed through Flexible Benefits Plan Dollars or otherwise allocated to the Health Savings Account of any Account Beneficiary, including any Qualified HSA Distributions and other allowable rollover contributions in accordance with the Employer's Adoption Agreement, shall be subject to the annual contribution limitations, applicable testing periods and other conditions set forth under Code Section 223(b) or as otherwise specified under the Employer's Adoption Agreement. Any excess contributions (as defined by Code Section 223(b)(3)(B)) made by any Account Beneficiary in accordance with these limitations shall be distributed in accordance with Code Section 223(b)(3)(A) or as otherwise directed by the HSA Trustee or Custodian.

10.10 COORDINATION WITH FLEXIBLE BENEFITS PLAN

All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Health Savings Account Program, as long as they otherwise meet the definition of an Eligible Individual set forth under this Article. The enrollment and termination of participation under the Flexible Benefits Plan shall constitute enrollment and termination of participation under this Health Savings Account Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Flexible Benefits Plan.

10.11 COORDINATION WITH HEALTHCARE EXPENSE REIMBURSEMENT PROGRAM

If the Employer offers the Healthcare Flexible Spending Program under this Plan to its Eligible Employees in addition to this Health Savings Account, to the extent an Eligible Individual elects to participate in both programs, any qualifying HSA Medical Expense amounts that can be paid under the Health Savings Account Program of this Plan may be paid under the Health Savings Account Program with the exception of those "limited benefits" (including vision and dental) in accordance with Code Section 223(c)(2)(B) that are to be paid from the Healthcare Flexible Spending Account.

10.12 HEALTH SAVINGS ACCOUNT PROGRAM CLAIMS

The HSA Trustee or other HSA Custodian shall make payment of eligible Health Savings Account claims to the Account Beneficiary, or any Designated Beneficiary, upon the presentation of documentation of such expenses in a manner specified by the HSA Trustee or Custodian of such account and in accordance with the method of benefit payment processes set forth under Article XII, as applicable.

10.13 DISTRIBUTIONS FOR NON-HSA EXPENSES

Any amounts within an Account Beneficiary's Health Savings Account may also be distributed under the following circumstances:

- a) **Non-HSA Expenses.** An Account Beneficiary, or any authorized representative upon death or disability, may make a request for distribution of any amount within the Health Savings Account that is not a qualifying HSA Medical Expense or has been denied in accordance with the procedures set forth under Section 10.12 above. The Trustee or HSA Custodian shall make distribution of such amounts to the Account Beneficiary, or any designated beneficiary, as soon as reasonably practicable after the Trustee or Custodian receives the Account Beneficiary's written distribution request, in accordance with the HSA Trustee or HSA Custodian's applicable procedures. Amounts distributed under these circumstances will be reported in accordance with applicable Federal and State law requirements.
- b) **Rollovers.** An Account Beneficiary may request that the balance of his or her Health Savings Account be distributed upon termination of employment, unless other terms and conditions are applicable under Section 2.7 above. The Trustee or HSA Custodian shall determine the manner of distribution of the Account Beneficiary's remaining Health Savings Account balance, minus applicable expense or other incurred HSA Medical Expenses not yet paid or reimbursed, either directly to the Account Beneficiary, or other designated beneficiary, or through a direct trustee-to-trustee transfer to another individual or employer Health Savings Account as directed in writing by the Account Beneficiary.
- c) **Domestic Relations Orders.** To the extent applicable and agreed to as part of its HSA Trustee or Custodial agreement, the Trustee shall comply with a domestic relations court order calling for the distribution of all or a portion of a Account Beneficiary's Health Savings Account to any current or former spouse, child or other dependent (the "Account Recipient") of the Account Beneficiary if such order is pursuant to a binding divorce or separation instrument meeting the standards of Code Section 71(b). Notwithstanding any other Plan restrictions or criteria set forth

above, even if a Account Beneficiary continues to be an Employee of the Employer or that the Alternate Recipient does not meet the eligibility criteria under Section 7.2(b)(2) set forth above, a binding domestic relations order may require distribution of all or a portion of the Account Beneficiary's Health Savings Account or maintenance of a portion of the Health Savings Account on the Alternate Recipient's behalf. The Trustee shall comply with the terms of any such order in the manner necessary under the then-existing circumstances as specified within its HSA Trustee or Custodial agreement. Amounts distributed under these circumstances will be reported in accordance with Code Section 223(h)(7) or as required under any other applicable Federal and State law.

ARTICLE XI

ERISA PROVISIONS

11.1 CLAIM FOR BENEFITS

- a) Any Claim for Benefits underwritten by an Insurance Contract shall be made to the Insurer. If the Insurer denies any Claim, the Participant or Beneficiary shall follow the Insurer's claims review procedure as set forth by the terms of that plan or other plan description. Any other Claim for Benefits shall be made to the Administrator. If the Administrator denies a Claim, the Administrator will provide notice to the Participant or Beneficiary, in writing, within 30 days after the Claim is filed unless special circumstances require an extension of time for processing the Claim. The notice of a denial of a Claim shall be written in a manner calculated to be understood by the Claimant and shall set forth:
- 1) The reason(s) for the denial;
 - 2) Specific reference to the provisions of the Plan on which the denial was based;
 - 3) A description of any additional material or information needed to further process the Claim and an explanation of why such material or information is necessary;
 - 4) A description of the Plan's review procedures and time limits applicable to such procedures, as well as the Participant's right to bring a civil action under Section 502 of ERISA following a final appeal;
 - 5) A statement of a Participant's right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;
 - 6) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon written request.
- b) Within 180 days after receipt of the above material, the Claimant shall have a reasonable opportunity to appeal the Claim denial to the Administrator for a full and fair review. The Claimant or his duly authorized representative may:

- 1) Request a review upon written notice to the Administrator;
 - 2) Review pertinent documents; and
 - 3) Submit issues and comments in writing, setting forth which of the reasons for denial that he/she disagrees with along with any supporting documents of additional comments related to the appeal.
- c) A decision on the review by the Administrator will be made not later than 30 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the Claimant, with specific references to the pertinent Plan provisions on which the decision is based.

11.2 APPLICATION OF BENEFIT PLAN SURPLUS

- a) Any balance remaining in the Participant's Insurance Benefit, Healthcare Flexible Spending Account, Dependent Care Assistance Account, and/or Adoption Assistance Account as of the end of each Plan Year, after consideration of any applicable Claim Extension Period or Carryover under this Plan, shall be forfeited and deposited, at the end of the run out period if applicable, in the "benefit plan surplus" of the Employer pursuant to Section 6.3, Section 7.8, or Section 8.8, whichever is applicable, unless the Participant had made a Claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the Claim shall be held in his/her account until the Claim appeal procedures set forth above have been satisfied or the Claim is paid. If any such Claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.
- b) Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner, as well as any previous checks that have been paid to a Participant but remain unendorsed, will be returned to the Employer after the close of the Plan Year (or after such further time specified herein for the filing of Claims) in which such forfeitures arose. With the exception of the Tax-Free Transportation Program or Health Savings Account Program, in no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury Regulations or any applicable State law. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses and thereafter be retained by the Employer. In addition, any account Benefit payments that are unclaimed (e.g., uncashed Benefit checks) by the end of the Plan Year following the Period of Coverage in which the medical care expense was incurred shall be forfeited and returned to the Employer.

11.3 NAMED FIDUCIARY

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

11.4 GENERAL FIDUCIARY RESPONSIBILITIES

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their Beneficiaries and

- a) For the exclusive purpose of providing Benefits to Participants and their Beneficiaries and defraying reasonable expenses of administering the Plan;
- b) With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- c) In accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

11.5 NONASSIGNABILITY OF RIGHTS

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

ARTICLE XII

ADMINISTRATION

12.1 PLAN ADMINISTRATION

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full authority and discretion to administer the Plan in all of its details or may delegate a portion of such authority to any third party, subject, however, to applicable requirements of law. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

- a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- b) To interpret the Plan, with the Administrator's interpretations thereof to be final and conclusive on all persons claiming Benefits under the Plan;

- c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive Benefits provided under the Plan;
- d) To reject elections or to limit contributions or Benefits for certain Highly Compensated Participants or other affected Participants if the Administrator deems such to be necessary in order to avoid discrimination under the Plan in violation of applicable provisions of the Code, or maintain compliance with any other applicable provisions of the Plan or other requirements of the law;
- e) To provide Employees with a reasonable notification of their Benefits available under the Plan;
- f) To approve reimbursement requests and to authorize the payment of Benefits; and
- g) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan; and
- h) To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be in writing.

Any determination by the Administrator shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Administrator acted arbitrarily and capriciously. Notwithstanding the foregoing, any claim which arises under any plan of Insurance Benefits selected by the Employer under Paragraph 8 of its signed Adoption Agreement shall not be subject to review under this Plan, and the Administrator's authority under this Section 12.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan or policy. Any procedure, discretionary act, interpretation, or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury Regulations thereunder.

12.2 METHOD OF BENEFIT PAYMENT

- a) The Administrator shall make, or otherwise direct any Trustee to make (if applicable) any and all payments or other reimbursements in the manner specified herein and as otherwise elected by the Employer (e.g., direct reimbursement by check, automatic deposit via automated clearing house (ACH)).
- b) If a Participant agrees to the terms and conditions of any applicable cardholder agreement that provides for the payment of qualifying Benefit expenses through use of a debit or credit card, stored value card or other similar electronic media (hereinafter the "Debit Card"), payments under this Plan shall be made directly to the service provider, authorized merchant, or other independent third party that provides products or services that are eligible for payment of qualifying Benefit expenses as otherwise set forth herein.
 - 1) Within the cardholder agreement, the Participant agrees that payment for qualifying Benefit expenses can only be made on behalf of the Participant, the Participant's Spouse, or other qualifying Dependents and is otherwise limited to

the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth in the Employer's signed Adoption Agreement or as otherwise specified by the Participant's signed Election. The Participant also certifies that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. The Participant-cardholder also understands that the certification, which shall be printed on the back of the Debit Card, is reaffirmed each time the card is used. The Participant-cardholder also agrees to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate or as required by law. The Participant-cardholder also understands that the Debit Card is automatically cancelled at termination of employment or under such other situations that are otherwise set forth within the cardholder agreement itself.

- 2) Unless other more stringent procedures or requirements are implemented and communicated to the Employer and its Employees, the Administrator agrees that it shall separately adhere to the terms and conditions of any separate Employer cardholder servicing agreement, including but not limited to, a requirement to maintain the program in compliance with applicable standards under the Code and any mandates that payments for Qualifying Expenses only be made to authorized merchants and service providers. The Administrator also agrees that it shall establish and maintain procedures for substantiation of any payments after the card has been used for qualifying Benefit payments that are in accordance with applicable provisions of the Code, any underlying Regulations and other applicable guidance thereunder.
- 3) If the Benefit reimbursement request is being submitted for any non-qualifying Benefit expense in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Administrator may make a conditional payment of an allowable Benefit item to the authorized service provider, merchant, or approved independent third party, but shall also require the Participant-cardholder to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which shall be subject to further review and substantiation.
- 4) If a Participant attempts to utilize the Debit Card or other form of electronic payment for any improper or non-allowable purpose, the Participant shall be responsible for any and all fees or other expenses, including restitution or other similar penalty amounts, charged inappropriately by the Participant.
- 5) If any conditional payment or other Benefit payment has been made but is not deemed to be qualifying Benefit expense reimbursement, the Administrator shall ensure that proper correction procedures are maintained with respect to the improper payment(s):
 - (a) Upon identification of any improper payment, the Administrator shall require the Participant to pay back to the Plan an amount equal to the improper payment;

- (b) If the Participant does not immediately repay the Plan, the Administrator shall ensure that the proper amount is withheld from the Participant's wages or other Compensation (with such amounts then being immediately remitted to the Plan by the Employer) to the extent consistent with applicable law;
- (c) To the extent that neither (a) nor (b) above are allowable or effective, the Administrator shall have the authority to utilize a Claim substitution or offset approach to resolve the improper Claim amount(s), with such methodology being clearly explained to the Participant-cardholder as part of his/her cardholder agreement.
- (d) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the Debit Card until the indebtedness is repaid by the Participant. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or Participant-cardholder agreement.

12.3 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee, and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours; provided, however, the Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

12.4 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Plan or by any Trust Fund that may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of Highly Compensated Employees.

12.5 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of a particular Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the Benefits Participants are entitled to, and the circumstances under which insurance terminates.

12.6 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs, and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE XIII

AMENDMENT OR TERMINATION OF PLAN

13.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any Benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, State, or local laws, statutes, or regulations.

13.2 TERMINATION

By signing the Adoption Agreement, the Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made and no further additions shall be made to the Insurance Benefit program, Healthcare Flexible Spending Account, Dependent Care Assistance Account, Adoption Assistance Account, Tax-Free Transportation Program, or Health Savings Account. Payments from such account(s)/program(s) shall continue to be made according to the elections in effect until the end of the Plan Year in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of Claims), or until the balances of all accounts have been reduced to zero, whichever occurs first. Any amounts remaining in any such account(s)/ program(s) as of the end of the Plan Year in which Plan termination occurs shall be forfeited and deposited in the benefit plan surplus after the expiration of the Claim filing period. The above notwithstanding, Benefits under any Insurance Contract shall be paid in accordance with the terms of that Contract.

ARTICLE XIV

HIPAA PRIVACY REQUIREMENTS

As of the required Effective Date, the Employer has implemented or amended the Plan to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in 45 C.F.R. Parts 190 through 164;

14.1 DEFINITIONS In addition to the specific definitions set forth below, all other capitalized terms used that are not otherwise defined herein have the meanings ascribed in HIPAA:

- a) **“Designated Record Set”** has the meaning in 45 CFR Section 164.501.
- b) **“Electronic Media”** has the meaning in 45 CFR Section 160.103, which is:
 - 1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
 - 3) Transmission media used to exchange information already in electronic storage media.
 - 4) Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
- c) **“Electronic Protected Health Care Information”** (also known as “ePHI”) has the meaning in 45 CFR Section 160.103, and is limited to the information created, maintained, transmitted or received by Business Associate from or on behalf of the Plan.
- d) **“Plan Administration Functions”** is defined as activities that would meet the definition of Payment or Healthcare Operations by HIPAA as set forth in 45 C.F.R. Section 164.501, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administration includes quality assurance, claims processing, auditing, monitoring, and management of carve-out plans (i.e., vision and dental). Plan administration does not include any employment-related functions or functions in connection with any other Benefits or Benefit plans, and the Plan(s) may not disclose information for such purposes absent an authorization from an individual for whom the information pertains. In addition, enrollment functions performed by the Employer are not considered Plan Administration Functions.
- e) **“PHI”** is defined as Protected Health Information, as set forth in 45 C.F.R. Section 164.501. It is information that is created or received by a health plan, employer, healthcare provider, or healthcare clearing house and includes information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. In addition, the information either identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. This information may be maintained or transmitted either electronically or in any other form or medium.
- f) **“Secretary”** means the Secretary of the Department of Health and Human Services or designee.

- g) **“Security Incident”** has the meaning in 45 CFR Section 164.304, which is: the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- h) **“Summary Health Information”** is defined by HIPAA as set forth in 45 C.F.R. Section 164.504 as information that may be PHI, and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided health benefits under the Plan; and from which the following information has been deleted, except that the geographic information described in 2) need only be aggregated to the level of a five-digit zip code:
- 1) Names;
 - 2) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:
 - (a) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
 - (b) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
 - 3) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
 - 4) Telephone numbers;
 - 5) Fax numbers;
 - 6) Electronic mail addresses;
 - 7) Social Security numbers;
 - 8) Medical record numbers;
 - 9) Health plan beneficiary numbers;
 - 10) Account numbers;
 - 11) Certificate/license numbers;
 - 12) Vehicle identifiers and serial numbers, including license plate numbers;
 - 13) Device identifiers and serial numbers;
 - 14) Web Universal Resource Locators (URLs);

- 15) Biometric identifiers, including finger and voice prints;
- 16) Full face photographic images and any comparable images; and
- 17) Any other unique identifying number, characteristic, or code.

14.2 DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan, its Administrator, or any contracted representatives of the Plan, may disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of:

- a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
- b) Modifying, amending, or terminating the Plan.

14.3 DISCLOSURE OF PHI

The Plan, its Administrator, or any contracted representatives of the Plan, may release PHI to the Employer, so long as the Employer agrees to do the following:

- a) The Employer shall not use or further disclose the PHI other than as permitted or required by the Plan's documents or as required by law;
- b) The Employer shall ensure that any agents, including a subcontractor, to whom it provides PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- c) The Employer shall not use or disclose the PHI for employment-related actions and decisions, or in connection with any other Benefit or employee Benefit plan of the Employer;
- d) The Employer agrees to report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures providing herein, if and when the Employer becomes aware of such inconsistent use or disclosure;
- e) The Employer, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.524 and consistent with the Employer Privacy Policy, has authorized the Plan to make PHI available to individuals;
- f) The Employer, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.524 and consistent with the Employer Privacy Policy, has authorized the Plan to make PHI available to individuals for amendment and to incorporate such amendments of PHI;
- g) The Employer, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.528 and consistent with the Employer Privacy Policy, has authorized the Plan to make available the information required to provide an accounting of disclosures;

- h) The Employer, agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for purposes of determining the Plan's compliance with HIPAA;
- i) If feasible, the Employer shall return or destroy all PHI that the Employer received from the Plan and which the Employer no longer needs for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible;
- j) The Employer agrees to use appropriate safeguards to prevent unauthorized use or disclosure of PHI, and have reasonable and appropriate safeguards in place to protect the confidentiality, integrity and availability of ePHI;
- k) The Employer agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement;
- l) The Employer agrees to report to the Plan, any use or disclosure of PHI of which it becomes aware that is not permitted or required by HIPAA; and
- m) The Employer agrees to report to the Plan any Security Incident of ePHI of which it becomes aware.

14.4 ADEQUATE SEPARATIONS

The Employer shall ensure that the following adequate separations are established:

- a) The Employer shall designate specific people who shall use and disclose PHI on behalf of the Plan for purposes of Plan Administration Functions.
- b) Access and use of PHI by the Group shall be limited to Plan Administration Functions that the Employer performs on behalf of the Plan;
- c) Any issues of noncompliance by the Group shall result in disciplinary measures specified in the Employer Privacy Policy.

14.5 USES AND DISCLOSURES

The Plan, its Administrator, or any contracted representatives of the Plan, may:

- a) Disclose PHI to the Employer in order for the Employer to carry out Plan Administration Functions consistent with the provisions of Subsections a) through i) and Subsection 14.4 above;
- b) Permit an insurance company, insurance service, insurance organization, or HMO to disclose PHI to the Employer, so long as the disclosure is made to an authorized person, and the disclosure is only for the purpose described in this Section 14.5;

- c) Not disclose or permit an insurance, insurance service, insurance organization, or HMO to disclose PHI to the Employer unless the Employer's privacy notice contains a provision which permits such disclosure; and
- d) Not disclose PHI to the Employer for the purpose of employment-related actions or decisions or in connection with any other Benefit or employee Benefit plan of the Employer.

ARTICLE XV

MISCELLANEOUS

15.1 PLAN INTERPRETATION

- a) All provisions of this Plan shall be governed and interpreted by the Administrator in its full and complete discretion and shall be otherwise applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 15.12.
- b) In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of the Administrators of the plans for any Insurance Benefits selected as part of Paragraph 8 of the signed Adoption Agreement, or by accountants, counsel, or other experts employed or engaged by the Administrator.

15.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine, or gender neutral, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

15.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document, which may be required by law, is intended to satisfy the written plan requirement of Code Section 125 and any Regulations thereunder relating to cafeteria plans.

15.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

15.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect that such discharge shall have upon him/her as a Participant of this Plan.

15.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

15.7 EMPLOYER'S PROTECTIVE CLAUSES

- a) Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect, or otherwise), the Participant's Benefits shall be limited to the insurance premium, if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's Claim.
- b) The Employer's liability to the Participant shall only extend to and shall be limited to any payment actually received by the Employer from the Insurer. In the event that the full insurance Benefit contemplated is not promptly received by the Employer within a reasonable time after submission of a Claim, then the Employer shall notify the Participant of such facts and the Employer shall no longer have any legal obligation whatsoever (except to execute any document called for by a settlement reached by the Participant). The Participant shall be free to settle, compromise, or refuse to pursue the Claim as the Participant, in his/her sole discretion, shall see fit.
- c) The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder 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, the Employer shall not be liable for any loss that may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

15.8 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's 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 any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for Federal and State income tax purposes, and to notify the Employer if the Participant has reason to believe that any

such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

15.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or State income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and State income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash Compensation, plus the Participant's share of any Social Security tax that would have been paid on such Compensation, less any such additional income and Social Security tax actually paid by the Participant.

15.10 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but shall instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.

15.11 GOVERNING LAW

This Plan is governed by the Code and the Treasury Regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced, and administered according to the laws of the State or Commonwealth identified as part of the Employer's completed Adoption Agreement.

15.12 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

15.13 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge, or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

15.14 CONTINUATION OF COVERAGE

Notwithstanding anything in the Plan to the contrary, in the event any Benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B.

15.15 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS (USERRA) ACT

Notwithstanding any provision of this Plan to the contrary, contributions, Benefits, and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

15.16 CLAIMS EXTENSION PERIOD

The provisions of the Plan concerning the payment of qualifying expenses or other similar benefits, which may include but is not limited to payment from healthcare flexible spending accounts, dependent care assistance accounts or other similar arrangements, that would otherwise be forfeited if not incurred by the end of the Plan Year are amended in the following respects:

- a) Claims Incurred Prior to the End of the Plan Year. For purposes of any provisions within the Plan that require qualifying expenses or other similar benefits to have been incurred by the end of the Plan Year to be eligible for reimbursement by the Plan, as of the Effective Date, the Plan shall also reimburse any qualifying expenses or other similar benefits that are incurred within the Claims Extension Period immediately following the end of the Plan Year. Any Plan provisions related to the deadline for forfeiture of any unused Plan accounts that are not utilized by the end of the Plan Year shall also take into consideration the Claims Extension Period.
- b) Claims Extension Period—Defined. For purposes of these rules, the “Claims Extension Period” shall be the period that ends on the 15th day of the third month immediately following the end of the most recent Plan Year.
- c) Order of Expense or Benefit Payment. Amounts remaining in the participant’s applicable flexible spending, health care reimbursement, dependent care assistance or other similar Plan account as of the end of the Plan Year shall be used first for the payment of any claims submitted during the Claims Extension Period. If all prior year amounts have been fully utilized, claims incurred during the Claims Extension Period shall be paid from any amounts elected for the Plan Year immediately coinciding with the Claims Extension Period. For these purposes, amounts remaining in one Plan account cannot be used to supplement the lack of available funds from another Plan account (e.g., excess amounts within a participant’s dependent care assistance account may not be used to fund flexible spending account health claims incurred during the Claims Extension Period).
- d) Forfeitures. Any amount(s) that remain as of the end of any Plan Year (including the processing all allowable claims submitted during the Claims Extension Period, pursuant to b) above) shall be forfeited and credited to any benefit plan surplus. In such

event, the Participant shall have no further claim to such amount for any reason, subject to any claims appeal rights otherwise set forth herein.

e) Claims Submission Deadline. All claims reimbursement requests must be submitted by the end of the month following the end of the Claim Extension Period deadline.

15.17 CARRYOVER PROVISION

The provisions of the Plan concerning the payment of qualifying expenses, which include payment from any healthcare flexible spending account that would otherwise be forfeited if not incurred by the end of the Plan Year, are as follows:

The Plan shall provide for a carryover of \$500 of any amount remaining unused in a healthcare flexible spending account as of the end of the Plan Year. Such carryover amount shall be used to pay or reimburse medical expenses under any healthcare flexible spending account incurred during the entire Plan Year to which it is carried over.

15.18 GENETIC INFORMATION NONDISCRIMINATION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

15.18 MENTAL HEALTH PARITY AND ADDICTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712. Specifically, as of January 1, 2010, the Plan shall no longer apply a specific annual or lifetime maximum coverage limitation, daily visit limitation or separate per day limit on coverage or services for mental and nervous disorders and/or substance abuse that is different from any other inpatient or outpatient treatment provided for under the Plan, and coverage shall be provided the same as any other medical procedure.

15.19 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act.

15.20 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

Summary Plan Description

For: Topeka & Shawnee County Public Library

Flexible Benefits Plan

Ending December 31st

FLEXIBLE BENEFITS PLAN

Summary Plan Description

INTRODUCTION

We are pleased to announce that we have established a Flexible Benefits Plan (the “Plan”) for you and other eligible employees. Under this program, you will be able to choose among certain Benefits that we make available. The Benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the Benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this summary plan description carefully so that you understand the provisions of our Plan and the Benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a Participant. You should direct any questions you have to the Administrator. There is a Plan Document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan Document, the Plan Document will control. Also, if there is a conflict between an Insurance Contract and either the Plan Document or this Summary Plan Description, the Insurance Contract will control.

GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information, which you may need to know about the Plan.

1. GENERAL PLAN INFORMATION

The **Topeka & Shawnee County Public Library** Flexible Benefits Plan is the name of the Plan.

2(a). NA.

2(b). **The provisions of the amended Plan became effective on January 1, 2014. The Plan was originally effective on January 1, 1996.**

3(a). **Your Plan's records are maintained on a 12-month period of time. This is known as the Plan Year. The initial plan begins on January 1, 2014 and ends on December 31, 2014. Future Plan Years will be based on a full 12-month period beginning on each January 1 and ending each December 31.**

3(b). NA

4. **Your Employer has assigned Plan Number 501 to your Plan.**

5. Employer Information

Your Employer's name, address, and identification number are:

**Topeka & Shawnee County Public Library
1515 SW 10th Avenue
Topeka, KS 66604-1374
48-6028929**

6. Plan Administrator Information

The name, address, and business telephone number of your Plan's Administrator (also referred to as the "Administrator") is:

**Topeka & Shawnee County Public Library
1515 SW 10th Avenue
Topeka, KS 66604-1374
785-580-4482**

The Administrator keeps the records for the Plan and is responsible for the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

7. Service of Legal Process

The Administrator is the Plan's agent for service of legal process.

8. Type of Administration

The type of Administration is Employer Administration.

9. Eligibility Requirements

(a) All Employees shall be eligible to participate in the Plan, except:

- Under the Healthcare Flexible Spending Account, employees not eligible under Employer group health insurance plan AND:

- Part-time Employees expected to work less than 20 hours per week.
- Commission salespersons.
- Any Employee who is temporary or seasonal (working for the Employer less than 6 months of the year).
- Any Leased Employee, as well as any independent contractor, or other "statutory employee" who is not treated as a common law employee of the Employer for payroll purposes, regardless of any other court or administrative agency determination.
-

(b) N/A

10. Entry Date.

The Entry Date for eligible Employees will be:

- First of month after hire date (but subject to any shorter limitation period if mandated under applicable law).

11. Under our Plan, you can choose to receive your entire Compensation or use a portion to pay for the following Benefits or expenses during the year:

- Healthcare Flexible Spending Account, subject to an annual limit of \$ 2,500;
- Dependent Care Assistance Program subject to the maximums contained in Section 7.9
- Employer Group Health Insurance (including health insurance, dental and vision insurance, AD&D, etc.);
- Group Term Life Insurance;
- Disability Insurance;

The applicable cost for any of these selected Benefits, enumerated above, will be paid for within each Participant's applicable Flexible Benefits Plan Dollars Account.

12. Contributions:

(a) The contributions for this Plan shall be:

Employee (Salary Redirection) contributions only;

(b) N/A

13. Maximum Contributions:

a) **The maximum amount you can contribute to the Healthcare Flexible Spending Account each Plan Year shall be \$ 2,500.**

b) **The maximum amount you can contribute to the Dependent Care Assistance Plan each Plan Year (or calendar year) shall be the lesser of: 1) \$5,000 (if you are married, filing a joint return or you are head of a household) or \$2,500 (if you are married, filing separate returns); 2) one-half of your taxable compensation; 3) your spouse's actual or deemed earned income (a spouse which is a full-time student or incapable of self-care has monthly earned income of \$250 for one dependent or \$500 for two or more dependents).**

c) NA

d) NA

14. Claims Incurred During the Claims Extension Period

The Plan Shall include the provision for "Claims Extension Period".

The Dependent Care and Adoption Assistance Programs Shall include the provision for "Claims Extension Period".

15. Carryover Provision – N/A

The Healthcare Flexible Spending Account Shall not include the provision for "Carryover".

16. Payment of HSA Medical Expenses During Claim Extension Period – N/A

17. Expense Allocation and Order of Benefit Payment – N/A

18. Rollovers of IRAs to HSA Accounts – N/A

Your Claims Administrator is:

**First Concord Benefits Group
PO Box 67220
Lincoln, NE 68506
TEL: 402-423-4454 / Toll Free: 1-800-206-9942
FAX: 402-423-4549**

II

ELIGIBILITY

1. **When Can I Become a Participant in the Plan?**

Before you become a member or a “Participant” in the Plan, there are certain rules that you must satisfy. First, you must meet the eligibility requirements. After that, the next step is to actually join the Plan on the Entry Date that we have established for all employees. You will also be required to complete certain application forms before you can enroll in the Plan. Please refer to Section I, “General Information About Our Plan” of this document for a description of the Entry Date for our plan.

2. **What are the Eligibility Requirements for our Plan?**

You will be eligible to join the Plan once you have satisfied the conditions for eligibility. If you are not eligible to participate in this Plan on the Effective Date of the Plan, you will be eligible to join the Plan once you have satisfied the eligibility requirements under this Plan. Please refer to Section I, “General Information About Our Plan” of this document for a description of our eligibility requirements.

3. **When is my Entry Date?**

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you met the eligibility requirements.

4. **Are there any Employees Who are not Eligible?**

Yes, there are certain employees who are not eligible to join the Plan. Please refer to Section I, “General Information About Our Plan” of this document for a description of ineligible employees.

5. **What Must I do to Enroll in the Plan?**

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the Benefits that are being offered under the Plan. You must also authorize us to set aside some of your earnings to pay for a portion of the Benefits you have elected.

However, if you are already covered under any of the insured Benefits, you will automatically participate in this Plan to the extent of your Premiums, unless during the Election Period, you elect not to participate in the Plan.

III

OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or accounts, which must be set up for you in order to pay for the Benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal or Social Security taxes and in most cases State income taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you would normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

IV

CONTRIBUTIONS

1. Will my employer make contributions to the Plan on my behalf?

Your Employer may choose to make contributions to the Plan to assist you in offsetting the cost of Benefits offered under the Plan. These Employer Contributions are referred to as “Flexible Benefits Plan Dollars.” Please refer to Section I, “General Information About Our Plan,” to determine what, if any, amount your Employer has indicated it will contribute towards the cost of your Benefits under this Plan.

2. How much of my pay may the employer redirect?

To the extent your Employer either does not provide Flexible Benefits Plan Dollars to this Plan or the cost of Benefits offered under the Plan are greater than the Flexible Benefits Plan Dollar amount provided by your Employer, you may make an election, known as a Salary Redirection, to make additional pre-tax contributions to the Plan from your own Salary amount. Each year, for the insured Benefits provided under this Plan we will automatically contribute on your behalf enough of your Compensation to pay for the insurance coverage provided. In addition, you may elect to pay for the Benefits that you elect under the Plan. These amounts will be deducted from your Compensation each pay period on a pro rata basis over the course of the year.

3. How is my compensation measured under the Plan?

Compensation under our Plan means the total cash amount that is paid to you each year.

4. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the Benefits you want and how much of the contributions should go toward each Benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered Benefit or expense during the Plan Year. Later, they will be used to pay for expenses as they arise during the Plan Year.

In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) by the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

5. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the Election Period. You must decide two things. First, which Benefits you want, and second, how much should go toward each benefit.

If you are already covered by any of the insured Benefits offered by this Plan, you will automatically become a Participant to the extent of the Premiums for such insurance unless, during the Election Period, you elect not to participate in the Plan.

6. When is the “Election Period” for our Plan?

Your election period will start on the date you first meet the eligibility requirements and end 30 days after your Entry Date. (You should review Section I, “General Information About Our Plan” and Section II, “Eligibility” to better understand the terms “eligibility requirements” and “Entry Date.”) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See Section I, “General Information About Our Plan” for the definition of “Plan Year.”)

7. May I change elections during the Plan Year?

Generally, no. You cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change if you have a “change in status,” you make an election change that is consistent with the change in status, and provided your request for change is made within 30 days from the date of change in status. Any new election will be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. Currently, Federal law considers the following events to be changes in status:

- a) Changes in legal marital status by you because of marriage, divorce, death of a spouse, legal separation, or annulment;

- b) Changes in the number of your dependents because of a dependent's birth, adoption, placement for adoption, or death;
- c) Changes in your employment status because of employment termination or commencement by you, your spouse, or a dependent; strike or lockout; the beginning or end of an unpaid leave of absence; or any other change in employment status that affects eligibility for benefits.
- d) Changes in one of your dependents who satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or a similar circumstance;
- e) Changes in health plan access due to a change in residence or worksite by you, your spouse, or a dependent that affect eligibility for benefits;
- f) Changes due to judgment, decree, or order resulting from divorce, legal separation, annulment, or change in legal custody, including a qualified medical child support order. You may also change an election to cancel coverage for the child if the order requires a former spouse to provide coverage for such child and such coverage is actually provided.
- g) Changes due to entitlement to Medicare or Medicaid.
- h) Changes due to entitlement to health insurance continuation coverage, as prescribed under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended; application of the Family and Medical Leave Act of 1993 ("FMLA"); or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, the Salary Redirection election you have made for the remainder of the Plan Year if there is a change in the premium expense. If there is an increase or decrease in premium expense that is significant, we will let you either make corresponding changes to the Salary Redirection election or allow you to revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may change or revoke your election. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly added option, elect another option if an option has been eliminated, or revoke your election. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Healthcare Flexible Spending Account, and you may not change your election to the Healthcare Flexible Spending Account if you make a change due to cost or coverage for insurance.

For the Dependent Care Assistance Program, a dependent becoming or ceasing to be your qualified dependent will qualify as a change in status. However, you may not change your election under the Dependent Care Assistance Program if it is due to a cost change, and a dependent care provider who is your relative imposes that change. You may, however, change your election under the Dependent Care Assistance Program if there is a cost change imposed by a non-related dependent care provider.

For the Adoption Assistance Program, a commencement or termination of an adoption proceeding will also qualify as a change in status.

Under current rules, there are no special provisions or other criteria for any type of qualified change in status circumstances under the Tax-Free Transportation Plan or Health Savings Account Program. Accordingly, changes to any existing elections to these plans will not be considered for these programs, unless described under any other specific provisions described elsewhere in this document or the Plan itself.

There may be other events considered to be a change in status as determined by the IRS Regulations. There are detailed rules on when a change in election is deemed to be consistent with a change in status. If you have any type of change in status, you should contact the Administrator, who will provide you with the required forms for changing your benefit elections.

The Administrator makes the determination of whether a valid change of status has occurred. In making this determination, the Administrator has the authority to require additional evidence to support your stated reasons for changing any prior benefit election.

8. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, you will be considered to have elected to have a portion of your pay redirected for the upcoming Plan Year for the Premium Expense and/or Tax-Free Transportation Program portion(s) of this Plan only. You would not be considered a Participant for the Healthcare Flexible Spending Account, the Dependent Care Assistance Account, Adoption Assistance Account, or Health Savings Account portions of the Plan without completion of new elections prior to the beginning of the subsequent Plan Year.

9. How does the Family and Medical Leave Act (FMLA) affect this Plan?

Generally, if you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your benefits under this Plan on the same terms and conditions as though you were still an active Employee. If you take a paid leave under the FMLA, you may participate in annual enrollment, and you will be required to continue coverage while on FMLA, your share of the Premiums being paid by the method normally used during any paid leave. If you take an unpaid leave under the FMLA, you may revoke or change your existing elections for health insurance and the Healthcare Flexible Spending Account, and participate in annual enrollment.

Or, your employer may choose to continue coverage on your behalf during your FMLA leave. In such situations, you would be entitled to receive reimbursement of any qualifying expenses that you incurred during your FMLA leave period. However, if you continue your coverage during your unpaid leave, you may continue to make payment for coverage under one of the following methods:

- a) **Prepayment.** Under the prepayment option, you can increase your Salary Redirection in an amount sufficient to cover the Premiums and other expenses that will come due during the FMLA leave.
- b) **Pay-as-you go.** With the pay-as-you-go option, you must continue to pay Premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while on

FMLA leave, the applicable Premiums are to be paid with pre-tax contributions as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid, the Administrator provides the funding for necessary coverage during the FMLA period, but you are required to reimburse the Employer at regular intervals with after-tax funds for the Premiums that come due during the leave.

- c) **Catch Up.** The Administrator provides the funding for necessary coverage during the leave and subsequently withholds “catch-up” amounts from your pay upon your return.

Upon return from such leave that has been or is being paid for under one of the methods referred to above, you will be permitted to re-enter the Plan on the same basis as you were participating in the Plan prior to your leave, or as otherwise required by the FMLA.

If your coverage in these Benefits terminates, due to your revocation of the Benefit while on leave or due to your non-payment of contributions, your coverage will be reinstated for the remaining portion of the Plan Year upon your return. However, for the Healthcare Flexible Spending Account, if your coverage terminates due to your revocation of the benefit while on leave or due to your non-payment of contributions, two options will be offered upon your return:

- a) **Proration.** The actual amounts contributed by you would remain available for your use the duration of the Plan Year, but the expenses you incur during that lapse in coverage would not be reimbursable and your maximum contribution amount would be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900; or...
- b) **Reinstatement.** You may elect to reinstate the level of coverage in effect when the leave began, with your maximum contribution level remaining the same as previously elected. Any deficiencies in contributions will be made up when you return based on a payment schedule that is established by your employer. You will not, however, be entitled to receive reimbursement of any expenses that you incur during any previous lapse in coverage.

In all instances, a paid or unpaid leave under FMLA will be treated in the same manner and consistent with a non-FMLA paid or unpaid leave.

10. How does the Uniformed Services Employment and Reemployment Rights Act (USERRA) affect this Plan?

If you are going into or returning from military service, you may have special rights to healthcare coverage under your Healthcare Flexible Spending Account and under the Health Savings Account, pursuant to USERRA. These rights can include extended healthcare coverage. If this law may affect you, ask your Administrator for further details.

11. What happens if I don't spend all Plan contributions?

It depends on the program in which you are enrolled. For example, if you are enrolled in either a Tax-Free Transportation Plan or a Health Savings Account, any unused amounts will be carried over to the next Plan Year and will generally be available for use in future years.

However, with respect to other Benefit options, subject to the applicable filing deadlines discussed in Article V, any contributed monies left at the end of the Plan Year will generally be forfeited. Having said this, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, if your Plan has adopted a Claims Extension Period (also known as an extended Grace Period) or Carryover Provision as further described within Section IX below, you have the additional period specified within Section I, “General Information About Our Plan”, to incur claims for you or your Dependents and still receive reimbursement for the Prior Year under the Plan. However, under all circumstances, you must make your requests for reimbursement no later than 90 days after the end of the Plan Year or by the end of the month following the end of the Claims Extension Period deadline.

Because a number of different options are available to you and it is possible that you might forfeit amounts in the Plan if you do not fully use or rollover any allowable contributions that have been made, it is important that you decide how much to place in each account carefully before the Plan Year begins. You want to be as certain as possible that the amount you decide to place in your accounts will be used entirely. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) by the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

V

BENEFITS

1. What benefits are available?

Under our Plan, you can choose to receive your entire compensation in cash or use a portion to pay for certain other benefits or expenses during the year. The benefits or expenses that are available for payment under the Plan have been selected by your Employer and are identified under Section I, “General Information About Our Plan,” referring to the Plan of Benefit Options. Notwithstanding the individual benefit selections that are available to you under your Plan, a discussion of pertinent issues that impact some of the more common benefit alternatives follows:

Premium Expense Account

A Premium Expense Account allows you to use tax-free dollars to pay for certain Premium Expenses under various Insurance Programs that we offer you. Please refer to Section I, “General Information About Our Plan,” Plan of Benefit Options, for information on Insurance Programs for which Premium Expenses can be paid for by our Plan.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any Insurance Contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance coverage terminates.

Any benefits to be provided by insurance will be provided only after 1) you have provided the Administrator the necessary information to apply for insurance, and 2) the insurance is in effect for you.

Healthcare Flexible Spending Account

The Healthcare Flexible Spending Account enables you to pay for expenses that are not covered by our health plan(s) and save taxes at the same time. The account allows you to be reimbursed by the Employer for out-of-pocket medical, dental, and vision expenses incurred by you, your spouse, and your dependents. A Limited-Purposed Healthcare Flexible Spending Account enables you to pay for only vision and dental expenses.

A medical expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when you are formally billed for, or are charged or, or pay for the medical care. The medical expenses, including any expense for medical care, which qualify are those permitted by Section 213(d) and Section 105 of the Internal Revenue Code and the rulings and Treasury Regulations thereunder. A list of covered expenses is available from the Administrator. (Please note that these covered expenses may also include the payment for certain over-the-counter medications.) You may not, however, be reimbursed for the cost of other healthcare coverage maintained outside of the Plan, or for long-term care insurance coverage or expenses. Effective January 1, 2011, over-the-counter drug expenses will not be reimbursed under the Plan, except as permitted by law.

Please refer to Section I, “General Information About Our Plan” for the maximum amount that you can contribute to your Healthcare Flexible Spending Account each Plan Year. In order to be reimbursed for a healthcare expense, you must submit your claim in the manner set forth under Section VI below. Reimbursement from the Plan will generally be paid no later than 90 days after receipt by the Administrator of a reimbursement claim.

Dependent Care Assistance Account

The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent daycare costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time instead of being gainfully employed (but note the income limitations discussed below). Single employees can also use the account, subject to the applicable dollar limitations specified below.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441, “Credit for Child and Dependent Care Expenses.” Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent care arrangements which qualify for expense reimbursement include:

- a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable State and local laws.
- b) An Educational Institution for pre-school children. For children beyond pre-school age (Kindergarten and above), only expenses for non-school care (e.g., after-care) are eligible.
- c) An individual who provides care inside or outside your home. The individual may not be a child of yours under age 19 or anyone you claim as a dependent for Federal income tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of: 1) \$5,000 (if you are married, filing a joint return or you are head of a household) or \$2,500 (if you are married, but filing separate returns); 2) your taxable compensation; 3) your spouse's actual or deemed earned income (a spouse who is a full-time student or incapable of self-care has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents), or such other amount as otherwise set forth and described under Section I, "General Information About Our Plan".

Also, in order to have reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan.

You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser which is better for you. Even if you do not take the Federal tax credit you will still be required to complete Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses" with your annual tax return.

Adoption Assistance Program– NOT APPLICABLE

The Adoption Assistance Program enables you to pay for out-of-pocket, qualifying adoption costs with pre-tax dollars, as well as possibly have all or a portion of amounts reimbursed under our Plan excluded from income, for tax purposes. The program allows you to be reimbursed by the Employer for reasonable and necessary adoption fees, courts costs, attorney fees, traveling expenses (including amounts spent for meals and lodging) while away from home, and other expenses directly related to the legal adoption of an eligible child (but not expenses that are in violation of State or Federal law, expenses incurred through a surrogate parenting arrangement, or expenses in connection with the adoption of a stepchild). It may also be a child within or outside of the United States, except to the extent it includes a child with special needs, as further described below.

An eligible child is a child who is under 18 years of age, or physically or mentally incapable of self-care, including a child with special needs. For these purposes, a "child with special needs" includes any child in which:

- a) A State has determined that the child cannot or should not be returned to the home of his/her parents;
- b) Such State has determined that there exists, with respect to the child, a specific factor or condition (such as his/her ethnic background, age, or membership in a minority or sibling group; or the presence of factors such as handicaps), because of which, it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance; and
- c) Such child is a citizen or resident of the United States (as defined in section 217(h)(3)).

The law places limits on the amount of money that can be paid to you in a calendar year from your Adoption Assistance Program. Generally, your reimbursements may not exceed \$13,190 in 2014 (in

total, as adjusted for inflation, as otherwise set forth and described under Section I, “General Information About Our Plan”) for each effort to adopt an eligible child. The amount and period within which you may claim reimbursement and/or exclusion from income can be different depending on whether it is the adoption of a child outside of the United States, a child with special needs, or other similar circumstances. You should contact the Administrator for more information about the options available to you and your situation.

In addition, Federal tax laws permit a tax credit for certain adoption expenses you may be paying for even if you are not a Participant in this Plan. You may take advantage of this tax credit and use the Adoption Assistance Program under our Plan if you have enough qualifying adoption expenses. However, certain income limitations under the Code may also limit your capability to utilize the credit or allow exclusion from income under our Plan. Please also note that even if you do not take the Federal tax credit, you may still be required to complete Federal Income Tax Form 8839, “Qualified Adoption Expenses,” with your annual tax return. You should ask your tax adviser when to take the credit or the exclusion from income under our Plan, as well as whether your personal income situation is at a level that could limit the amount of benefit you might receive under this program and any other income reporting responsibilities you may have under these circumstances.

Tax-Free Transportation Program: – NOT APPLICABLE

The Tax-Free Transportation Program enables you to pay for eligible transportation expenses costs with pre-tax dollars, as well as possibly have all or a portion of amounts reimbursed under our Plan excluded from income for tax purposes, as long as such amounts are not greater than the allowable monthly maximum amount, which is otherwise set forth and described under Section I, “General Information About Our Plan”. The use of pre-tax dollars reduces your taxable income and you save Social Security and income taxes on the amount of your Salary Redirection. Eligible transportation expenses include:

- a) **“Parking Expense,”** defined as expenses incurred to park your car on or near the business premises of your Employer or expenses incurred to park your car at a location from which you commute to work by 1) mass transit facilities, 2) a Commuter Highway Vehicle, or 3) carpool;
- b) **“Transit Pass Expenses,”** defined as expenses incurred for a pass, token, fare card, voucher, or similar item (a “Pass”) for transportation 1) on mass transit facilities, whether or not publicly owned, or 2) provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver);
- c) **“Commuter Highway Vehicle (Vanpool) Expenses,”** defined as expenses incurred for transportation in a “commuter highway vehicle” if such transportation is in connection with travel between your residence and place of Employment. A Commuter Highway Vehicle is any highway vehicle with a seating capacity of at least six adults (not including the driver), and for which at least 80 percent of the mileage is for purposes of transporting employees in connection with travel between their residences and their places of employment, and on trips during which the number of employees transported for such purposes is, on average, at least half of the adult seating capacity of the vehicle (not including the driver).

Unless other allowable payment processes are set forth to make payment or reimbursement for you or on your behalf in another manner under Section VI below, when you incur an expense that is eligible for

payment, you must complete and submit a Request for Reimbursement Form (which will be supplied to you) to the Employer within 180 days of the date you incur the expense. Requests must be submitted for expenses incurred for an entire month; no partial-month requests will be considered for payment. As a general rule, you must submit a receipt (or other third party verification) along with your claim form.

If your reimbursement request was for less than your current Tax-Free Transportation Program Account balance, the unused amounts in your Account will be available for future reimbursements. You may need to adjust the election for the next coverage period in order to use up your surplus Account balance.

For example, if your monthly parking election (and anticipated monthly expense) is \$100, but you only incur \$75 worth of eligible parking expenses in January, you might want to change your election for February to \$75 in order to use up the \$25 surplus from January. Then you can increase your election to \$100 for March prior to March 1.

If your reimbursement request was for an amount that was less than the monthly maximum amount (as otherwise set forth and described under Section I, “General Information About Our Plan”), but more than your current Tax-Free Transportation Program Account balance, the excess part of the reimbursement will be carried over into following months to be paid out as your balance becomes adequate (subject to the monthly maximum). You may not be reimbursed for any expenses that arise before your Salary Redirection agreement becomes effective.

If you are provided a transit pass that is purchased directly by the Employer, or if other electronic payment processes are allowable under your Plan in accordance with Section VI below, your Account will be debited directly for the cost of the transit pass. You will not need to submit a request for reimbursement form.

In addition, you will have 90 days after the end of the Plan Year in which to submit a Request for Reimbursement Form for eligible transportation expenses incurred during the previous Plan Year. You will be notified in writing if any request for reimbursement is denied.

If you have any funds in your Account at the time you terminate employment, any amounts not applied for eligible transportation expenses incurred prior to the termination and unclaimed within 90 days of your termination of employment will be forfeited.

Health Savings Account (HSA) – NOT APPLICABLE

In addition to the Healthcare Flexible Spending Account, this Plan also may provide for the payment of other qualifying medical expenses not paid for through an insurance plan through the use of a “Health Savings Account (HSA).” This type of program is intended to enable eligible individuals who elect to participate in this program to submit claims for the reimbursement of eligible HSA medical expenses or allow distribution of remaining balances for other qualifying purposes (although income taxation may result if distributions are made for non-medical expense reimbursements as discussed below).

In general, unless otherwise excluded from participation under this program under Section I above, all Participants under the Flexible Benefits Plan are eligible to receive Benefits under this HSA Program, as long as they otherwise meet the definition of an “Eligible Individual” as defined below. The enrollment and termination of participation under the Flexible Benefits Plan shall constitute enrollment and termination of participation under this HSA Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Flexible Benefits Plan.

For HSA purposes, you are an “Eligible Individual” who may participate in the HSA if you or your covered Dependents are:

- a) Covered under a qualifying High-Deductible Health Plan (that is provided through your Employer);
- b) Not an individual that may be claimed as a dependent by another person for tax purposes, under Code Section 151; and
- c) Not covered under any other health plan (other than stand-alone dental, vision, accidental death and dismemberment, long-term care, or other similar type of policy or program of coverage, including insurance for a specified disease or illness).

Please note, however, that you will no longer be considered as an “Eligible Individual” that is entitled to receive additional contributions of Flexible Benefits Plan Dollars to any HSA under this Plan when you become enrolled in Medicare benefits under Title XVII of the Social Security Act. Subject to applicable filing deadlines, you would, however, be entitled to still utilize the balance of any remaining amounts that remain within your HSA at the time of Medicare enrollment.

Once eligible and elected, the Administrator will establish a Health Savings Account for each person who elects to apply Flexible Benefits Plan Dollars or IRA rollovers, as applicable, to HSA Program benefits (subject to annual contribution limits set forth above and in accordance with applicable Code requirements; contributions made in excess of allowable annual limits would be subject to applicable excess contribution penalties). If elected under your Employer's Adoption Agreement (and as identified under Section I, “General Information About Our Plan”), you may be eligible to submit expenses under your HSA during any existing Claim Extension Period, as long as your Healthcare Flexible Spending Account is deemed to have a "zero balance account" as of the end of the last Plan Year, after consideration of any applicable Qualified HSA Distribution. You should also note that certain contributions to the HSA may be subject to additional income and excise taxes if applicable Testing Periods established under Code Section 223 are not satisfied. You should contact the Administrator regarding the impact of any of these special rules or any applicable tax ramifications that may result under your situation.

Under this program, as an Eligible Individual that is enrolled in the HSA, you and your dependents are entitled to receive reimbursement under the HSA for qualifying medical expenses that, unless otherwise provided for under this Plan (as identified under Section I above), are for the cost of medical care (as defined under Code Section 213(d)), but only to the extent not compensated by or paid for by insurance (or unless it is for the purchase of coverage that is allowable under Code Section 223(d), which includes among other costs, COBRA, long-term care insurance, unemployment coverage, Medicare, etc.). You should make sure that the medical expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Health Savings Account. For example, you cannot be reimbursed for expenses incurred before you became eligible under the Plan, nor can you be reimbursed for amounts that exceed the balance that remains in your account.

If all other criteria have been established, all HSA claims incurred by you or your qualifying dependents shall be reimbursed during the Plan Year, even though the submission of such a claim may occur after your eligibility participation hereunder ceases, provided that the HSA expenses were incurred during the applicable Plan Year and after you became eligible under this Plan. Claims shall generally be payable in accordance with the Benefit Payments provisions described under Section VI below.

You may also request distribution of all or a portion of your existing HSA balance for any other reason. Such amounts will be paid to you, your dependents or other qualifying beneficiary(ies) as soon as administratively feasible. However, to the extent such distributions are for other than actual reimbursement of qualifying HSA expenses, the amount distributed will be subject to income tax and a 20 percent excise tax penalty. Exceptions may exist in circumstances where the distribution is being made pursuant to an employee's death or disability. You should contact the HSA Trustee or Custodian for additional information on allowable distributions made at or subsequent to an employee's death or disability.

Your Health Savings Account will be increased each pay period by the portion of Flexible Benefits Plan Dollars that you elect to apply toward your HSA, as well as can be increased by any rollover amounts that are accepted by this Plan from another qualifying HSA or allowable Individual Retirement Account. Your Employer also has the ability to make pre-tax contributions to your HSA account on your behalf, although remaining subject to the same annual contribution limitation set forth above, as well as must adhere to existing nondiscrimination requirements as applicable. Correspondingly, your HSA balance will be reduced by the amount of any qualifying HSA medical expenses reimbursements paid by the HSA Trustee or Custodian on behalf of you or your qualifying dependents. Your HSA balance will also be reduced for any other distributions made in accordance with the terms of the Plan, any applicable rollovers to any other HSA plan and, if elected by your Employer, for any depreciation in interest earnings or other investment accumulations that have resulted during the Plan Year.

By the deadline set forth in accordance with your Plan, the Administrator will provide you with at least an annual statement of all contributions made to the HSA as well as such benefits or other distributions paid to or on your or your dependent(s) behalf during the prior calendar year. The amount in any remaining HSA balance as of the end of any Plan Year (and after the processing of all claims for such Plan Year) will be carried over and available for use in the subsequent Plan Year (in addition to any further contribution amounts or other Flexible Benefits Plan Dollar contributions made during the next Plan Year(s)).

If your Employer offers the Healthcare Flexible Spending Account Program under this Plan in addition to this HSA, to the extent you elect to participate in the HSA and the Healthcare Flexible Spending Account Program, any qualifying medical expense amounts that can be paid under the HSA Program of this Plan may be paid by the HSA (through submission of those claim reimbursement requests to the HSA Trustee or HSA Custodian) with the exception of "limited benefits" (i.e., vision and dental benefits) that may be paid concurrently from the Healthcare Flexible Spending Program through submission of claim requests to the Administrator.

VI

BENEFIT PAYMENTS

1. How do I request reimbursements from my account?

During the course of the Plan Year, you may submit requests for reimbursement of expenses that you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when they are paid for. The Administrator will provide you with forms, or other online claim processing instructions, for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement, which is payment, soon

thereafter. Remember, reimbursements that are made from the Plan are generally not subject to Federal income tax or withholding. Nor are they subject to Social Security taxes. Also note that you must submit all requests for reimbursement of any health care, dependent care, or adoption expenses no later than 90 days after the end of the Plan Year, or as of a later date if your Employer has adopted a Claims Extension Period, as otherwise described under Section IX below. Requests for payment of insured benefits should be made directly to the Insurer. The provisions of the insurance policies will control what benefits will be paid and when. You will only be reimbursed from the Dependent Care Assistance Plan, Adoption Assistance Program, Tax-Free Transportation Program, or Health Savings Accounts to the extent that there are sufficient funds in the applicable accounts to cover your request.

2. How are benefits paid to me?

- a) The Administrator will make any and all payments or other reimbursements to you as soon as administratively feasible or as otherwise set forth herein and will be distributed in the manner elected by your Employer (including direct reimbursement by check, automatic deposit via automated clearing house (ACH)).
- b) As an alternative to the method of Benefit payment referenced above, if you agree to the terms and conditions of any applicable cardholder agreement (that is also agreed to by your Employer and the Administrator, with any additional provisions or requirements) that provides for the payment of qualifying Benefit expenses through use of a debit or credit card, stored value card or other similar electronic media (generally referred to as the "Debit Card"), payment of qualifying Benefit expenses may be made directly to the service provider, authorized merchant, or other independent third party using claim substantiation procedures and policies in accordance with existing IRS guidelines and other applicable laws set forth below:
- c) If the Benefit reimbursement request is being submitted for any nonqualifying Benefit expense in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Administrator will make a conditional payment of an allowable Benefit item to the authorized service provider, merchant, or approved independent third party, but will also require you to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which will be subject to further review and substantiation;
- d) If any conditional payment or other Benefit payment has been made but is not deemed to be a qualifying expense reimbursement, the Administrator will ensure that proper correction procedures are maintained with respect to the improper payment(s):
 - (1) Upon identification of any improper payment, the Administrator will require you to pay back to the Plan an amount equal to the improper payment;
 - (2) If you do not immediately repay the Plan, the Administrator will ensure that the proper amount is withheld from your wages or other compensation (with such amounts then being immediately remitted to the Plan by your Employer) to the extent consistent with applicable law;

- (3) To the extent that neither (1) or (2) above are allowable or effective, the Administrator shall have the authority to utilize a claim substitution or offset approach to resolve the improper claim amount(s), with such methodology being clearly explained to you as part of your cardholder agreement;
- (4) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the Debit Card until the indebtedness is repaid by you. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or your cardholder agreement.

Under all circumstances, you must agree that payment for qualifying Benefit expenses can only be made on behalf of you, your spouse, or other qualifying dependents and is otherwise limited to the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth herein.

By signing the cardholder agreement, you are also certifying that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. You are also certifying that you understand this agreement is reaffirmed each time the card is used. You will further agree to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate. Lastly, in signing the cardholder agreement, you certify that you understand that the Debit Card is automatically cancelled at termination of employment or under such other situations that are otherwise set forth within the cardholder agreement itself.

If you attempt to utilize the debit card or other form of electronic payment for any improper or non-allowable purpose, you will be responsible for any and all fees or other expenses, including restitution or other similar penalty amounts, charged inappropriately by you.

3. What happens if I terminate employment?

If you leave our employ during the Plan Year, your right to benefits will be determined in the following manner:

- a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- b) You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care Assistance Account at the time of termination of employment, provided the expenses are submitted no later than 90 days after the end of the Plan Year. However, no further salary redirection and Employer contributions will be made on your behalf after you terminate.
- c) You will still be able to request reimbursement for qualifying adoption expenses for the remainder of the Plan Year from the balance remaining in your Adoption Assistance Account at the time of termination of employment provided the expenses are submitted no later than 90 days after the end of the Plan Year. However, no further salary redirection and Employer contributions will be made on your behalf after you terminate.

- d) Under the Health Savings Account, you may submit qualifying expenses for reimbursement under the Plan that were incurred prior to your date of termination, request distribution of any remaining HSA balance amounts, or roll over any unused HSA balance to another qualifying HSA established on your own or through another employer. You may contact the HSA Trustee or Custodian for more information as to how to transfer any such amounts under these circumstances.
- e) You may elect to continue your participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year subject to current COBRA provisions (including applicable provisions that may reduce or eliminate your ability to maintain COBRA eligibility). Please refer to the initial COBRA notification in Attachment A for additional information. The Plan Administrator will notify you as to your COBRA eligibility (if any) at the time of your qualifying event.
 - 1) If you elect to continue your participation in the Healthcare Flexible Spending Account, you must continue to make any required contributions to the Plan at the same level you had prior to your termination. Depending on the elections made by your Employer, you may be able to continue making such contributions on a pre-tax basis if you continue to receive compensation after your termination from employment. Otherwise, your contributions would be required on an after-tax basis only.
 - 2) If you elect not to continue participation in the Healthcare Flexible Spending Account, participation will cease and no further salary redirection and Employer contributions will be made on your behalf.
 - 3) If your participation in the **Healthcare Flexible Spending Account ceases**, you will be able to submit claims for healthcare expenses incurred prior to your date of termination provided the expenses are submitted no later than 90 days after the end of the prior Plan Year, if you are employed at the end of the Plan Year, or **within 90 days of your date of termination** for all other circumstances.

4. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced. That is because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VII

HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to Highly Compensated Employees?

Under the Internal Revenue Code, “Highly Compensated Employees” and “Key Employees” generally are Participants who are officers, shareholders, or highly paid employees. You will be notified by the

Administrator each Plan Year whether you are a “Highly Compensated Employee” or a “Key Employee.”

If you are within these categories, the amount of contributions and benefits paid for you under this Plan may be limited so that the Plan, as a whole, does not unfairly favor those who are highly paid, their spouses, or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the Key Employees if they, as a group, receive more than 25 percent of all of the nontaxable benefits provided for under our Plan.

Your own circumstances will dictate whether contribution limitations on “Highly Compensated Employees” or “Key Employees” will apply. You will be notified of these limitations if you are affected.

VIII

PLAN ACCOUNTING

The Administrator will make available to you a statement of your account during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember that you want to spend all of the money you have designated for a particular benefit by the end of the Plan Year.

IX

ADDITIONAL PLAN INFORMATION

1. Your rights under ERISA

Plan participants, eligible employees, and all other employees of the Employer are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that participants, eligible employees, and all other employees are entitled to:

- a) Examine, without charge, at the Administrator’s office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and
- b) Obtain copies of all Plan documents and other Plan information upon request to the Administrator. The Administrator may charge a reasonable fee for the copies.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the best interest of you and other plan participants.

No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit 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 your claim reviewed and reconsidered.

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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$110 (or such greater amount as determined by the U.S. Department of Labor) 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.

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.

If you have any questions about this statement or your rights under ERISA you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

2. Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later than 90 days after the end of a Plan Year; unless your Plan has adopted the "Claims Extension Period" or "Carryover Provision". Any claims submitted after that time will not be considered. Claims for benefits that are insured will be received in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include:

- a) The reasons for the denial;
- b) Reference to the specific provisions of the Plan on which the denial was based;
- c) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;
- d) A description of the Plan's review procedures and time limits applicable to such procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;
- e) A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;

- f) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request.

You or your beneficiary will have 180 days following the receipt of any notification of claim denial to appeal the decision, making a written request for reconsideration to the Administrator. Documents, comments, records, or any other information in support of your appeal should be submitted in writing and accompany any such request. You or your beneficiary may review pertinent documents and receive copies of all documents and records, free of charge.

The Administrator will review the claim, without deference to the initial denial and after taking into account all comments, information, documents, records, and other information submitted as part of the appeal. Unless a 15-day written extension is utilized to review further information, the Administrator will provide a written response to the appeal within 120 days from the date of receipt of any appeal request. In this response, the Administrator will explain the reason for the decision, with reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to review and interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

3. CLAIMS INCURRED DURING THE “CLAIMS EXTENSION PERIOD”

The provisions of the Plan concerning the payment of qualifying expenses or other similar benefits, which may include, but is not limited to payment from, health care reimbursement accounts, dependent care assistance accounts or other similar arrangements, that would otherwise be forfeited if not incurred by the end of the Plan Year. The provision for the “Claims Extension Period” under the Plan is identified under Section I, “General Information About Our Plan”. Please refer to “General Information About Our Plan” to determine if this provision applies to your Plan.

1. Claims Incurred Prior to the End of the Plan Year. For purposes of any provisions within the Plan that require qualifying expenses or other similar benefits to have been incurred by the end of the Plan Year to be eligible for reimbursement by the Plan, as of the Effective Date of this amendment, the Plan shall also reimburse any qualifying expenses or other similar benefits that are incurred within the Claims Extension Period immediately following the end of the Plan Year with amounts remaining in the participant’s applicable flexible spending, health care reimbursement, dependent care assistance or other similar Plan account as of the end of the Plan Year. Any Plan provisions related to the deadline for forfeiture of any unused Plan accounts that are not utilized by the end of the Plan Year shall also take into consideration the Claims Extension Period.
2. Claims Extension Period—Defined. For purposes of these rules, the “Claims Extension Period” shall be the period that ends on the 15th day of the third month immediately following the end of the most recent Plan Year. For example, if your Plan Year ends on December 31st, you have until March 15th of the following Plan Year to incur and submit qualifying expenses during the Claims Extension Period.
3. Order of Expense or Benefit Payment. Amounts remaining in the participant’s applicable flexible spending, health care reimbursement, dependent care assistance or other similar Plan account as of the end of the Plan Year shall be used first for the payment of any claims submitted during the Claims Extension Period. If all prior year amounts have been fully utilized, claims incurred during the Claims Extension Period shall be paid from any amounts elected for the Plan Year immediately coinciding with the Claims Extension Period. For these purposes, amounts remaining in one Plan account cannot be

used to supplement the lack of available funds from another Plan account (e.g., excess amounts within a participant's dependent care assistance account may not be used to fund flexible spending account health claims incurred during the Claims Extension Period).

4. Forfeitures. Any amount(s) that remain as of the end of any Plan Year (including the processing of all allowable claims submitted during the Claims Extension Period, pursuant to Section 1 above) shall be forfeited and credited to any benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to any claims appeal rights otherwise set forth herein.

5. Claims Submission Deadline. All claims reimbursement requests must be submitted by the end of the month following the end of the Claim Extension Period deadline. For example, if your Plan Year ends on December 31st, and your Claims Extension Period ends on March 15th, you have until April 30th to submit claims incurred during the previous Plan Year and the Claims Extension Period.

4. Carryover Provision

The Plan provides for a carryover of \$500 of any amount remaining unused in your healthcare flexible spending account as of the end of the Plan Year. You may use this carryover amount to pay or be reimbursed for medical expenses under any healthcare flexible spending account incurred during the entire Plan Year to which it is carried over.

The carryover will be available to you on the first day of any new Plan Year for expense incurred in the previous or new Plan Year.

5. HIPAA Privacy

Title II of the Health Insurance Portability and Accountability Act of 1996 and the regulations at 45 CFR Parts 160 through 164 ("HIPAA"), contain provisions governing the use and disclosure of Protected Health Information by health plans, and provide privacy rights to Participants in those plans. HIPAA applies to the Plan Year of this Plan.

Protected Health Information or "PHI" is health information that is created or received by the Plan. PHI relates to your physical or mental health or condition, the provision of health care to you, or the payment for the provision of health care to you. Typically, the information identifies you, your diagnosis, and treatment or supplies used in the course of your treatment.

The Plan may disclose PHI to the Employer only for limited purposes as described in the Plan's documents. The Employer agrees to use and disclose PHI only as permitted or required by the Plan's documents or as required by HIPAA. PHI may be used or disclosed for plan administration functions that the Employer performs on behalf of the Plan. Such functions include:

- Enrollment of Eligible Employees and their eligible dependents
- Eligibility determinations
- Payment for coverage
- Claim payment activities
- Coordination of benefits

- Claim appeals

In order to perform these functions, the Plan will use and disclose PHI only to the following individuals:

- Plan Administrator
- HIPAA Privacy Official
- Other Personnel, specifically designated by the Plan's Privacy Official

The Plan shall maintain policies and procedures that govern the Plan's use and disclosure of PHI, as well as the use and safeguarding of electronic PHI that is otherwise subject to applicable HIPAA Security guidelines as well. These policies and procedures include provisions to restrict access solely to the above individuals and only for the functions listed above. The Plan's policies and procedures also include a mechanism for resolving issues of noncompliance. A notice has been provided to you summarizing the Plan's policies and procedures. A copy of this notice is also attached as Attachment B.

X

SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities, and save for the future. Our Flexible Benefits Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Plan Administrator listed under Section I, "General Information About Our Plan."

Attachment A

****CONTINUATION COVERAGE RIGHTS UNDER COBRA****

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The 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 your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under Federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. 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 coverage under the Plan is lost because of the qualifying event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose your coverage under the 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 employee, you will become a Qualified Beneficiary if you lose your coverage under the 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;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

You may elect to continue participation in the Plan in accordance with proposed IRS Regulations. However, unless the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") applies to your Plan, the continuation coverage will be offered until the end of the Plan Year in which the qualifying event occurs. COBRA continuation coverage generally will not be offered to Healthcare Flexible Spending Account Participants under the following circumstances:

- a) The Healthcare Reimbursement Account has a deficit at the time of the qualifying event. If, taking into account all claims submitted on or before the date of the qualifying event, your remaining Healthcare Flexible Spending Account balance for the Plan Year is less than the maximum required COBRA Premiums for the rest of the year.
- b) COBRA continuation will not be offered to a Healthcare Flexible Spending Account Participant in any Plan Year following the Plan Year in which the qualifying event occurs if:
 - 1) The Healthcare Flexible Spending Account is Exempt from HIPAA. The Healthcare Flexible Spending Account is exempt from HIPAA if a major medical plan is available in addition to the Healthcare Flexible Spending Account, and the Healthcare Flexible Spending Account benefit does not exceed two times the salary redirection or, if greater, the salary redirection plus \$500; and
 - 2) For the Plan Year in which the qualifying event occurs, the maximum amount you could be required to pay for a full year of Healthcare Flexible Spending Account

COBRA coverage equals or exceeds the maximum benefit available to you for the Plan Year.

However, your Employer may choose to offer COBRA continuation coverage, notwithstanding the exceptions detailed above. If your Employer chooses to provide such additional COBRA continuation coverage, you will be provided with additional information about any other rights you may also have at that time.

You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Please refer to Section I, "General Information About Our Plan" of this document for your Plan Administrator's name and address

How is COBRA coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his/her employment terminates, COBRA continuation coverage for his/her spouse and children 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). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at 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. You must provide written notice of any such disability, along with copies of any such written determination received from the Social Security Administration and the date it was received, to: [Name of the appropriate party to

whom notice must be sent]. This information must be received by the applicable Plan representatives no less than 30 days before the end of the 18-month continuation coverage period.

Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your 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, 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 Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep your Plan Administrator informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

For more information about the Plan and your rights thereunder, contact the Plan Administrator listed under Section I, "General Information About Our Plan."

Attachment B

****HIPAA NOTICE OF PRIVACY PRACTICES****

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Purpose

This notice is intended to inform you of the privacy practices followed by your employer's Healthcare Flexible Spending Account Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan sponsor your employer often needs access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information

Healthcare Operations. We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as a merger,

sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you \$0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Requirements

We are required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact the Plan Administrator listed under Section I, "General Information About Our Plan."

Filing a Complaint

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information.