# FLEXIBLE BENEFITS PLAN

# MASTER PLAN DOCUMENT

**Note: This Flexible Benefits Plan Master Plan Document describes all Flexible Benefits Plan provisions administered by the Claims Administrator. Some of the Flexible Benefits Plan provisions described in this document may not apply to your Plan. Consult the Plan Information Appendix to this document to see which provisions of this document apply to your Plan. If you have any questions, contact the Claims Administrator.**

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# FLEXIBLE BENEFITS PLAN

## ARTICLE I

## GENERAL

**Sec. 1.1 Name of Plan.** The name of the plan set forth herein is specified in the Plan Information Appendix. It is sometimes herein referred to as the "Flexible Benefits Plan" or the "Plan".

**Sec. 1.2 Purpose.** The purpose of the Plan is to furnish employees an opportunity to receive certain statutory nontaxable benefits provided by Employer in lieu of taxable Compensation or other statutory nontaxable fringe benefits. The Plan is intended to be a cafeteria plan under Section 125 of the Internal Revenue Code, so that the benefits a Participant elects to receive under the Plan will be eligible for exclusion from the Participant's gross income under Section 125(a) of the Code.

**Sec. 1.3 Effective Date.** The "Effective Date" of the Plan is the date as of which the Plan was established and is specified in the Plan Information Appendix. If the Plan is amended and restated as set forth herein, the effective date of the amended and restated Plan is specified in the Plan Information Appendix.

**Sec. 1.4 Rules of Construction.** The Plan is intended to be a cafeteria plan under Section 125 of the Internal Revenue Code. The Plan shall be administered and construed consistent with said intent. It shall also be construed and administered according to the laws of the state listed in the Plan Information Appendix, to the extent that such laws are not preempted by the laws of the United States of America. Because it is sponsored by a governmental entity, neither this Plan, nor any portion of this Plan, is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, as from time to time amended ("ERISA"). All references herein to the "Internal Revenue Code" or the "Code" are to the Internal Revenue Code of 1986 as from time to time amended. The Plan shall be construed in accordance with the following rules:

(a) This document, plus its appendices (including the Plan Information Appendix), are intended to constitute the Plan document required by the Code.

(b) Headings at the beginning of articles and sections hereof are for convenience of reference, shall not be considered a part of the text of the Plan, and shall not influence its construction.

(c) Capitalized terms used in the Plan shall have the meaning defined in the Plan unless the context clearly indicates to the contrary.

(d) Any references to the masculine gender include the feminine and vice versa.

(e) Use of the words "hereof", "herein", "hereunder", or similar compounds of the word "here" shall mean and refer to the entire Plan unless the context clearly indicates to the contrary.

(f) The provisions of the Plan shall be construed as a whole in such manner as to carry out the provisions hereof and shall not be construed separately without relation to the context.

## ARTICLE II

## DEFINITIONS

**Sec. 2.1 Account.** An "Account" or "Accounts" shall be established for each Participant by the Employer. Each Account shall be credited as provided in Article IV, and shall be decreased by benefit payments and distributions to the Participant under Article IV and under the Appendices. Accounts are for bookkeeping purposes only and are not required to be set aside from the other assets of the Employer. The following Accounts will be established, if specified in the Plan Information Appendix, for a Participant:

(a) A Health Care Flexible Spending Account for reimbursement of medical expenses, including dental and vision expenses, under Appendix A.

(b) A Limited Health Care Flexible Spending Account for reimbursement of certain limited expenses as identified in the Plan Appendix under Appendix B.

(c) A Dependent Care Flexible Spending Account for reimbursement of dependent care expenses under Appendix C.

(d) An Individual Health Premium Account for reimbursement of individual health coverage premiums under Appendix D.

**Sec. 2.2 Benefit Plan.** "Benefit Plan" means a plan sponsored by the Employer consisting of an insurance or similar program, health maintenance organization, trust fund, or direct payment arrangement maintained by the Employer for the purpose of providing certain specified medical, dental or other welfare benefits for employees, and their dependents. The Benefit Plans for which premiums may be paid under the Plan shall be identified in the Plan Information Appendix.

**Sec. 2.3 Compensation.** "Compensation" means earned income, salary, wages, fees, commissions, overtime, bonuses, tips, and all other earnings of a Participant, reportable on Form W-2 for the Plan Year, including amounts contributed by a Qualified Employee to the Plan, but excluding all other contributions to any other plan sponsored by the Employer and all other forms of compensation.

**Sec. 2.4 Election.** If a Participant chooses to participate in one or more Benefit Plans, any portion of the premium payments not paid by the Employer will be paid pursuant to Sec. 4.1, unless the Participant signs a waiver instructing the Employer to deduct such premiums on an after-tax basis. If the Individual Health Premium Payment Feature is applicable as specified in the Plan Information Appendix, any Premium for the Individual Health Coverage (as defined in Appendix E) will be paid pursuant to Sec. 4.1, unless the Participant signs a waiver instructing the Employer to deduct such premiums on an after-tax basis. If Health Savings Account contributions are permitted under the Plan, as specified in the Plan Information Appendix, a Participant also may file an Election to contribute to a Health Savings Account under Sec. 4.5. During each applicable Election Period, a Participant may file an Election designating the Account credits under Sec. 4.3 desired by the Participant. Elections shall be subject to the following rules:

(a) The Election shall be in writing on a form provided by the Employer, shall be filed with the Employer, and shall specifically indicate the amounts to be allocated to each Account of the Participant. An Election meeting the requirements of the Plan and not inconsistent with its terms shall be irrevocable after the last day of the Election Period in which it is filed, subject to any changes made in a new Election filed in a subsequent Election Period in accordance with Sec. 2.5(a).

(b) Except as provided in subsection (c) below, an Election filed in an annual Election Period prior to the beginning of a Plan Year shall be effective on the first day of the Plan Year with the deductions effective for each payroll period for purposes of salary reduction credits under Sec. 4.3, unless a new Election is made in an Election Period resulting from a change in the Participant's status as described in Sec. 2.5(a).

(c) An election filed prior to the beginning of any month to contribute to a Health Savings Account, if Health Savings Account contributions are permitted under the Plan as specified in the Plan Information Appendix, shall be effective on the first day of the month immediately following the date the Election is received.

(d) An Election filed in an Election Period during a Plan Year pursuant to Sec. 2.5 shall be effective as of the date specified in Sec. 2.5. The Election will be reflected in the Participant's payroll as soon as administratively feasible following the date the Election is filed.

(e) If a Participant returns from a leave of absence during the calendar year in which the leave began, any Election that was in effect when the leave began shall continue in effect until the next Election Period, with an appropriate adjustment of the amount reimbursable from the Participant's Accounts to reflect any contributions the Participant did not make during the Participant's absence. If the Participant returns from the leave in a subsequent calendar year, the Participant shall be treated as becoming a Qualified Employee again on the date the leave ended and a new Election Period will be provided pursuant to Sec. 2.5(b).

**Sec. 2.5 Election Period.** The "Election Period" for an Election to have the Employer pay on a pre-tax basis the Participant's share of any premium or cost required for group or individual coverage under Sec. 4.1 or for an Election to have the Employer credit salary reduction credit amounts to the Participant's Accounts under Sec. 4.3 is the period designated by the Employer ending prior to the first day of the Plan Year. The "Election Period" for Health Savings Account contributions, if they are permitted under the Plan, as specified in the Plan Information Appendix, is the month preceding the month in which the Participant wishes to make a contribution under Sec. 4.5.

In addition, the following are Election Periods:

(a) If any of the following special election events occur during the Plan Year with respect to a Participant, then the 30-day period immediately following the date the event occurs, or such other time period as may be specified below, shall be an Election Period for said Participant with respect to the remainder of the Plan Year and, if elected in the Plan Information Appendix, the corresponding Grace Period:

(1) Benefit Plan, Individual Health Premium Account, and Individual Health Premium Payment Feature Elections. The following events that occur during the Plan Year are special election events that permit a change in the Participant's Benefit Plan, Individual Health Premium Account, and Individual Health Premium Payment Feature Elections for the remainder of the Plan Year:

(A) Change in Status Events. The following change in status events permit a Participant to change his or her Benefit Plan, Individual Health Premium Account, or Individual Health Premium Payment Feature Election if the change is on account of and consistent with the change in status and the

event affects the Participant's or the Participant's Spouse's or Tax Dependent's eligibility or possible eligibility for coverage under this Plan, a Benefit Plan or any other health care flexible spending account, medical plan, dental plan or other health plan providing health coverage pursuant to Code Section 105 that is sponsored by the Employer or the Participant's Spouse's or Tax Dependent's employer:

(i) The Participant legally marries (under applicable state and federal law).

(ii) The Participant divorces, or legally separates from, his or her Spouse, or has his or her marriage to his or her Spouse annulled.

(iii) The Spouse or a Tax Dependent of the Participant dies.

(iv) The Participant gains or loses a Tax Dependent (e.g., a child is born to, adopted by, or placed for adoption with the Participant, a child of the Participant dies).

(v) The Participant's Spouse or Tax Dependent becomes employed or ceases to be employed.

(vi) The Participant or the Participant's Spouse or Tax Dependent has a change in terms and conditions of employment or has a reduction or increase in hours of employment, including a change from part-time to full-time status or vice versa, taking or returning from an unpaid leave of absence, or a strike or lock-out.

(vii) A Tax Dependent of the Participant becomes or ceases to be eligible for coverage as a result of a change in age, student status, or other similar circumstances.

(viii) The Participant or the Participant's Spouse or Tax Dependent has a change in place of residence or worksite.

(B) HIPAA Special Enrollment Rights. The Participant may change his or her Benefit Plan, Individual Health Premium Account, or Individual Health Premium Payment Feature Elections consistent with an enrollment in a Benefit Plan under the special enrollment provisions of the Health Insurance Portability and Accountability Act.

(C) COBRA Continuation Coverage. The Participant may increase his or her salary reduction contributions to pay any additional premium as a result of Participant, Spouse or Tax Dependent becoming eligible for continuation coverage under the Employer's Benefit Plan pursuant to Section 2201 through 2008 of the Public Health Services Act or any similar state statute, so long as the Participant remains eligible to participate in the Plan.

(D) Support Order. The Participant, or the Plan if the Participant does not take the required action, may add coverage in accordance with a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires coverage for a Participant's child or for a foster child who is a Tax Dependent of the Participant. The Participant may eliminate coverage for a child if a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody requires that coverage of that child be provided by an individual other than the Participant and that coverage is in fact provided.

(E) Change in Medicare or Medicaid Entitlement. The Participant may change his or her coverage Election consistent with a change in entitlement to Medicare or Medicaid, including a loss of entitlement, by the Participant or the Participant's Spouse or Tax Dependent.

(F) Change in Other Coverage. The Participant may change his or her coverage Elections if: (i) a group health plan or Code Section 125 cafeteria plan covering the Participant's Spouse or Tax Dependent permits a change in health coverage at a time other than an Election Period under this Plan as a result of a change in status event as described in subparagraph (a)(1)(A), a general enrollment period, or another change in coverage permitted by the applicable Treasury Regulations; (ii) the Spouse or Tax Dependent elects a change in coverage; and (iii) the Participant's change in coverage under this Plan is on account of and consistent with the change in the Spouse's or Tax Dependent's coverage.

(G) Change in Cost or Coverage Options. An Election Period shall be deemed to have occurred, resulting in a new Election for the remainder of the Plan Year automatically adjusting the Participant's salary reduction contributions during the Plan Year, or commencement of salary reduction contributions in an appropriate manner in the case of a Qualified Employee who had not previously elected to participate, in any of the following circumstances:

(i) The premium under any Benefit Plan or the "Individual Health Coverage" (as defined in Appendix D or E) is significantly increased during the Plan Year and the Participant elects to continue the existing coverage, elects coverage under another Benefit Plan or Individual Health Coverage with similar coverage, or elects no Benefit Plan coverage or Individual Health Coverage if no similar coverage is available.

(ii) The premium under any Benefit Plan or Individual Health Coverage is significantly decreased during the Plan Year and the Participant or Qualified Employee elects coverage under that Benefit Plan or Individual Health Coverage.

(iii) The premium under any Benefit Plan or Individual Health Coverage is increased or decreased during the Plan Year by an insignificant amount.

(iv) The coverage under a Benefit Plan or Individual Health Coverage is significantly curtailed during the Plan Year and the Participant elects to receive, on a prospective basis, coverage under another plan with similar coverage.

(v) The coverage under a Benefit Plan or Individual Health Coverage ceases during the Plan Year and the Participant either elects to receive, on a prospective basis, coverage under another Benefit Plan or Individual Health Coverage with similar coverage or elects no Benefit Plan coverage or Individual Health Coverage if no similar coverage is available.

(vi) A new coverage option is added to a Benefit Plan, a new Individual Health Coverage option is added under the Plan or an existing coverage option is significantly improved, and the Participant or Qualified Employee elects that new coverage option.

(H) Loss of group health coverage sponsored by a governmental or educational institution. The Participant may change his or her Benefit Plan, Individual Health Premium Account, and Individual Health Premium Payment Feature Elections consistent with a loss of coverage by the Participant or the Participant's Spouse or Tax Dependent under any group health coverage sponsored by a governmental or educational institution.

(I) Family and Medical Leave Act. A Participant taking leave under the Family and Medical Leave Act may change his or her Benefit Plan Election as provided by that Act and applicable regulations or rulings thereunder.

(2) Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account Elections. The following events that occur during the Plan Year are special election events that permit a change in the Participant's Health Care Flexible Spending Account Election or Limited Health Care Flexible Spending Account Election for the remainder of the Plan Year and, if elected in the Plan Information Appendix, the corresponding Grace Period, provided that any such Election may not reduce the total amount to be credited to the Participant's Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account for the Plan Year to less than the amount of eligible expenses incurred by the Participant prior to the effective date of the new Election.

(A) Change in Status Events. The change in status events listed in subparagraph (a)(1)(A) also apply to allow a Participant to change his or her Health Care Flexible Spending Account Election or Limited Health

Care Flexible Spending Account Election if the change is on account of and consistent with the change in status and the event affects the Participant's or the Participant's Spouse's or Tax Dependent's eligibility or possible eligibility for coverage under this Plan, a Benefit Plan or any other health care flexible spending account, medical plan, dental plan or other health plan providing health coverage pursuant to Code Section 105 that is sponsored by the Employer or the Participant's Spouse's or Tax Dependent's employer. Notwithstanding the foregoing, the change in Election must not violate the risk shifting characteristics of the Health Care Flexible Spending Account or the Limited Health Care Flexible Spending Account.

(B) Support Order. The Participant may increase coverage in accordance with a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires coverage for a Participant's child or for a foster child who is a Tax Dependent of the Participant. The Participant may decrease coverage if a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody requires that coverage of a child be provided by an individual other than the Participant and that coverage is in fact provided.

(C) Change in Medicare or Medicaid Entitlement. The Participant may change his or her coverage Election consistent with a change in entitlement to Medicare or Medicaid, including a loss of entitlement, by the Participant or the Participant's Spouse or Tax Dependent.

(D) Family and Medical Leave Act. A Participant taking leave under the Family and Medical Leave Act may change his or her coverage Election as provided by that Act and applicable regulations or rulings thereunder.

(3) Dependent Care Flexible Spending Account Election. The following events are special election events that permit a change in the Participant's Dependent Care Flexible Spending Account Election for the remainder of the Plan Year.

(A) Change in Status Events. The change in status events listed in subparagraph (a)(1)(A) also apply to allow a Participant to change his or her Dependent Care Flexible Spending Account Election if the change is on account of and consistent with the change in status and the event affects the cost of dependent care expenses described in Code Section 129. In addition, the following special rules apply to Dependent Care Flexible Spending Account Elections:

(i) For purposes of the change in status events, "Tax Dependent" refers to a "Qualifying Individual" as defined in Appendix C.

(ii) An election change is consistent with a change in status if the event affects the eligibility of the Participant or the Participant's Spouse or Qualifying Individual for coverage under the Plan.

(B) Change in Other Coverage. The Participant may change his or her Dependent Care Flexible Spending Account Election if: (i) a Code Section 125 cafeteria plan covering the Participant's Spouse or Qualifying Individual permits a change in the Dependent Care Flexible Spending Account Elections at a time other than an Election Period under this Plan as a result of a change in status event as described in subparagraph (a)(1)(A), a general enrollment period, or another change in coverage permitted by the applicable Treasury Regulations; (ii) the Spouse or Qualifying Individual elects a change in coverage; and (iii) the Participant's change in coverage under this Plan is on account of and consistent with the change in the Spouse's or Qualifying Individual's coverage.

(C) Change in Cost or Coverage Options. The Participant may change his or her Dependent Care Flexible Spending Account Election in either of the following circumstances:

(i) The cost of dependent care is significantly increased or decreased during the Plan Year by a dependent care provider who is not a relative of the Participant and the Participant either elects to continue the existing dependent care or elects a new provider.

(ii) The Participant elects to change dependent care providers or elects not to have a dependent care provider and the cost of dependent care increases or decreases.

(4) Medical Plan Premium Elections. The following events that occur during the Plan Year are special election events that permit a change in the Participant's Election regarding payment of medical plan premiums for the remainder of the Plan Year:

(A) Reduction in Hours Without Loss of Eligibility. A Participant who has made an Election to pay for group medical coverage may revoke that payment Election if the following conditions are satisfied:

(i) The Participant has been in an employment status under which the Participant was reasonably expected to average at least thirty (30) hours of service per week;

(ii) The Participant has experienced a change in employment status such that the Participant will reasonably be expected to average less than thirty (30) hours of service per week after the change but nevertheless will remain eligible for group medical coverage;

(iii) The Participant cancels group medical coverage in accordance with the requirements of that plan; and

(iv) The Participant and any related individuals who were also enrolled in the group medical coverage have enrolled or intend to enroll in other medical coverage that provides minimum

essential coverage and such coverage will be effective no later than the first day of the second month following the month in which coverage under the Employer's group medical coverage ends. The Plan Administrator may rely on the Participant's reasonable representation that the requirement described in this paragraph (iv) has been satisfied.

(B) Participant's Enrollment in Marketplace Coverage. A Participant who has made an Election to pay for group medical coverage may revoke that payment Election if the following conditions are satisfied:

(i) The Participant either is eligible to enroll in a qualified health plan through the Marketplace (i.e., a public exchange) via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance) or seeks to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(ii) The Participant cancels group medical coverage in accordance with the requirements of that plan; and

(iii) The Participant and any related individuals who were also enrolled in the group medical coverage have enrolled in a qualified health plan through the Marketplace and such coverage will be effective no later than the day immediately following the last day for which the Employer's group medical coverage was effective (i.e., there is no break in coverage). The Plan Administrator may rely on the Participant's reasonable representation that the requirement described in this paragraph (iii) has been satisfied.

(5) Any Election may be changed with respect to any Benefit Plan or Account pursuant to any other event so recognized under applicable Federal regulations.

(6) Any such election during the period described above must be consistent with the change in status resulting from the event described above. The Employer will not accept any election during said Election Period which it deems to be inconsistent with the change in status. Furthermore, the Employer will not accept any election regarding credits to a Participant's Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account which would reduce the total number of credits to the Account for the Plan Year below the amount of benefit payments to the Participant that have been made with respect to such Account previously during that Plan Year.

(7) If Health Savings Account contributions are permitted under the Plan, as specified in the Plan Information Appendix, a Participant may start or stop an Election to contribute to a Health Savings Account or increase or decrease the Election at any time as long as the change is effective prospectively. Because the eligibility requirements and contribution limits for Health Savings Accounts are determined on a monthly as opposed to a Plan Year basis, the change in status

events listed in subsections (a)(1), (a)(2), and (a)(3) above do not apply to Participant contributions to Health Savings Accounts.

(8) Elections as a result of birth or adoption are effective as of the date of the event. All other Elections under this Section are effective as of the date of the Election, generally, the date the Election form is signed. The change in the Election will be reflected in the Participant's payroll as soon as administratively feasible following the date the Election is filed. For the effective dates described in this subsection to apply, the Election must be filed within thirty (30) days of the event.

(b) If any of the following situations apply to an employee, an Election Period will be provided for that employee as follows:

(1) With respect to an individual who becomes a Qualified Employee with the Employer during a Plan Year, the Election Period for that Plan Year shall be the thirty (30) days preceding the entry date specified in the Plan Information Appendix. If the entry date specified in the Plan Information Appendix is the Qualified Employee's date of hire, the Qualified Employee may begin participating in the Plan on his or her date of hire even if he or she does not submit the election form prior to that date, provided the Qualified Employee's election is made within thirty (30) days of his or her hire date. In such case, salary reduction contributions to pay for coverage during the period preceding the date of the Qualified Employee's election to participate shall be taken prospectively from compensation paid following the election.

(2) If a Participant returns from an unpaid leave of absence in a subsequent calendar year, or is rehired as a Qualified Employee, either in a subsequent calendar year or in the same calendar year but more than thirty (30) days following his or her Termination of Employment, the Participant shall be treated as becoming a Qualified Employee again on the date the leave ended or the rehire occurred and a new Election Period will be provided pursuant to paragraph (1), except that the Election Period will not end earlier than thirty (30) days after the date the individual again became a Qualified Employee. If the Participant returns from the leave during the calendar year in which the leave began, or is rehired within thirty (30) days of the date of his or her Termination of Employment and in the same calendar year in which the Termination of Employment occurred, any Election that was in effect when the absence began shall continue in effect until the next Election Period, with an appropriate adjustment of the amount reimbursable from the Participant's Accounts to reflect any contributions not made by the Participant during the period of absence.

(c) The Election Period under subsection (a) or (b) may be extended by the Employer for a Participant upon showing that the Participant's failure to meet the deadline was the result of good cause and was not the fault of the Participant.

**Sec. 2.6 Employer.** The "Employer" is specified in the Plan Information Appendix.

**Sec. 2.7 Grace Period.** The "Grace Period" is the two (2) month and fifteen (15) day period following the end of the Plan Year. The Grace Period, if elected in the Plan Information Appendix, applies to the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending

Account. The Grace Period does not apply to the Dependent Care Flexible Spending Account or the Individual Health Premium Account.

**Sec. 2.8 Health Savings Account.** A "Health Savings Account" means a Health Savings Account established under Code Section 223.

**Sec. 2.9 Participant.** A "Participant" is an individual described as such in Article III.

**Sec. 2.10 Participating Employer.** If the Employer is a governmental entity, **"**Participating Employer" means any governmental entity that is affiliated with the Employer and that is designated by the Employer in the Plan Information Appendix as covered by this Plan. If the Employer is a church, **"**Participating Employer" means any entity that is affiliated with the Employer, that is treated as a single employer with the Employer under Section 414 of the Code, and that is designated by the Employer in the Plan Information Appendix as covered by this Plan. When referred to in Secs. 2.1, 2.2, 2.3, 2.5, 2.14, 2.17, 3.2, 4.2, 4.3, 4.5, 4.6, 4.7, 4.10. 4.11, and 4.13 of the Plan, the term "Employer" includes all Participating Employers, if any. Participating Employers are designated in the Plan Information Appendix.

**Sec. 2.11 Plan Administrator. "**Plan Administrator" means the Employer.

**Sec. 2.12 Plan Year.** A "Plan Year" is the 12-consecutive-month period (except in cases of a short Plan Year) commencing on the date specified in the Plan Information Appendix and is the year on which records of the Plan are kept.

**Sec. 2.13 Post-Deductible Expenses.** Expenses that are incurred after the minimum annual deductible under Code Section 223(c)(2)(A)(i) is satisfied. If the Participant and/or the Participant's Spouse or Dependent has something other than single coverage under the high deductible health plan, then the minimum annual deductible provided under Code Section 223(c)(2)(A)(i) for family coverage applies; if neither the Participant nor the Participant's Spouse or Dependents has something other than single coverage under the high deductible health plan, then the minimum annual deductible provided under Code Section 223(c)(2)(A)(i) for single coverage applies.

**Sec. 2.14 Qualified Employee.** An employee of the Employer is a "Qualified Employee" for each payroll period that the employee meets the eligibility requirements specified in the Plan Information Appendix, subject to the following:

(a) Eligibility of employees in a collective bargaining unit to participate in the Plan shall be subject to negotiations with the representative of the unit. During any period that an employee is covered by the provisions of a collective bargaining agreement between the Employer and such representative, the employee shall not be considered a Qualified Employee unless such agreement provides coverage for such employee under the Plan. For purposes of this Section only, such an agreement shall be deemed to continue after its formal expiration during collective bargaining negotiations pending the execution of a new agreement.

(b) A leased employee within the meaning of Code Section 414(n)(2) is not a Qualified Employee.

(c) A nonresident alien within the meaning of Code Section 7701(b)(1)(B) while not receiving earned income (within the meaning of Code Section 911(d)(2)) from the Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) is not a Qualified Employee.

(d) An employee is not a Qualified Employee unless his or her services are performed within the continental United States (including Alaska) or Hawaii, or the principal base of operations to which the employee frequently returns is within the continental United States (including Alaska) or Hawaii.

(e) Notwithstanding anything herein to the contrary, an individual is not a Qualified Employee during any period during which the individual is classified by the Employer as an independent contractor or as any other status in which the person is not treated as a common law employee for purposes of withholding of taxes, or is treated as an employee of another entity who is leased to the Employer, regardless of the correct legal status of the individual. The previous sentence applies to all periods of such service of an individual who is subsequently reclassified as an employee, whether the reclassification is retroactive or prospective.

(f) If an employee's employment status changes from a Qualified Employee to a non-Qualified Employee position, the employee shall cease to be a Qualified Employee as of the date the employee is no longer a Qualified Employee. If an employee's employment status changes from a non-Qualified Employee position to a Qualified Employee position, the employee shall be a Qualified Employee as of the date the change in employment status takes place.

**Sec. 2.15 Spouse.** "Spouse" means an individual who is (a) legally married to a Participant (under applicable state law), and (b) treated as a "Spouse" under the applicable section of the Code.

**Sec. 2.16 Tax Dependent.** "Tax Dependent" means an individual (other than the Participant and the Participant's Spouse) with respect to whom amounts expended for medical care are excluded from the Participant's gross income under Section 105(b) of the Code, as amended. The definition "Tax Dependent" herein is different than the definition of tax dependent applicable under the Internal Revenue Code for purposes of identifying whom a taxpayer may claim as an exemption on his or her federal income tax return and is different than the definition of "qualifying individual" that applies under the Dependent Care Flexible Spending Account.

**Sec. 2.17 Termination of Employment.** The "Termination of Employment" of an employee for purposes of the Plan shall be deemed to occur upon the employee's resignation, discharge, retirement, death, failure to return to active work at the end of an authorized leave of absence or the authorized extension or extensions thereof, failure to return to work when duly called following a temporary layoff, or upon the happening of any other event or circumstance which, under the policy of the Employer results in the termination of the employer-employee relationship.

## ARTICLE III

## PARTICIPATION

**Sec. 3.1 Participation.** Each person who is a Qualified Employee shall become a Participant on the effective date of any Election filed during an Election Period to have premiums paid by salary reduction under Sec. 4.1, to have credits made by salary reduction to one or more Accounts under Sec. 4.3, or, if Health Savings Account contributions are permitted under the Plan, as specified in the Plan Information Appendix, to have contributions made to a Health Savings Account under Sec. 4.5.

**Sec. 3.2 Enrollment Procedures.** To become a Participant, the individual must complete the proper forms required by the Employer and must file the forms with the Employer, or must follow such other enrollment procedures as the Employer may require. Any Election under this Plan must be made during an Election Period and shall be effective as described in Sec. 2.4 and 2.5. An individual who does not enroll during his first Election Period under Sec. 2.5(b) may not enroll as a Participant until the next applicable Election Period.

**Sec. 3.3 Cessation of Participation.** A person shall cease to be a Participant as of the earliest of (i) the date the Participant has a Termination of Employment, (ii) the date the Participant ceases to be a Qualified Employee, or (iii) the effective date of any election by the Participant to terminate all salary reductions under Secs. 4.1, 4.3, and 4.5; provided that, if elected in the Plan Information Appendix, participation will cease under (i) or (ii) on the last day of the month in which the Participant has a Termination of Employment or ceases to be a Qualified Employee, as the case may be. If a Participant ceases to be a Qualified Employee during the Plan Year, that will not prevent him/her from filing a claim for reimbursement of eligible expenses incurred during the portion of a Plan Year prior to the date on which he/she ceased to be an Eligible Employee, plus, in the case of the Dependent Care Flexible Spending Account and the Individual Health Premium Account, eligible expenses incurred during the remaining portion of the Plan Year, to the extent a balance then exists in his/her Account. Such a claim shall be subject to the same rules as apply under this Plan to claims submitted after the end of a Plan Year by Participants. If a Participant ceases to be a Qualified Employee during the corresponding Grace Period for a Plan Year, if elected under the Plan Information Appendix, that will not prevent him/her from filing a claim for reimbursement for eligible expenses incurred under the Health Care Flexible Spending Account or the Limited Health Care Flexible Spending Account during the Plan Year or the corresponding Grace Period, to the extent a balance exists in his/her Account, provided he/she was a Qualified Employee on the last day of the Plan Year. Terminated employees have until the date on or before ninety (90) days following the Termination of Employment to submit claims incurred while a Participant under the Health Care Flexible Spending Account or the Limited Health Care Flexible Spending Account. Terminated employees have until the date on or before ninety (90) days following the end of the Plan Year including the Termination of Employment to submit claims incurred under the Dependent Care Flexible Spending Account and the Individual Health Premium Account.

## ARTICLE IV

## CREDITS AND ACCOUNTS

**Sec. 4.1 Salary Reduction Contributions to Pay Premiums.** During an Election Period, unless the Participant signs a waiver instructing the Employer to pay the premiums on an after-tax basis, each Participant automatically elects to have the Employer pay on a pre-tax basis (i) the Participant's share of any premium or cost required for group coverage which the Participant has elected under any Benefit Plan, to the extent such cost is not covered by Employer credits pursuant to Sec. 4.2 if any, and (ii) the Participant's premium for individual coverage obtained under the Individual Health Premium Payment Feature. The Participant's Compensation shall be reduced by an amount equal to the amount paid by the Employer on the Participant's behalf under this Section.

**Sec. 4.2 Employer Credits.** If specified in the Plan Information Appendix, the Employer may grant a credit to each Participant for purposes of selecting among the benefits available under the Plan for each period during the Plan Year. Prior to each Plan Year, the Employer shall determine the dollar amount of the credits, if any, that it will make available to Participants under this Plan during the Plan Year. The dollar amount of the credits may vary for different classes of employees as determined in the sole discretion of the Employer. Employer credits are subject to the following:

(a) The Employer credits for the period specified in the Plan Information Appendix shall become available for use under the Plan as of the date specified in the Plan Information Appendix.

(b) No amounts shall be credited to a Participant after his or her Termination of Employment, or, if earlier, after he or she ceases to be a Qualified Employee.

(c) The Employer credits shall first be used to pay for the cost for the Participant's elected coverage, if any, under the Benefit Plans. The balance remaining shall next be allocated among the other benefits available under the Plan (e.g., the Accounts), as specified in the Participant's Election. Finally, if any credits remain, the balance shall be handled in accordance with the Plan Information Appendix. If the Participant fails to file an Election, the credits shall be paid to the Participant in cash, subject to any restrictions specified in the Plan Information Appendix. Amounts that a Participant elects to receive or is deemed to have elected to receive in cash shall be paid to the Participant on a pro-rata basis over the course of the Plan Year in substantially equal installments. Such payments will be added to the Participant's paycheck and are fully taxable as additional compensation. Cash payments shall be made only to Participants. If a Participant ceases to be a Qualified Employee, then cash payments cease.

(d) Employer credits that are not used to reimburse eligible expenses incurred during the Plan Year may be used to reimburse eligible expenses incurred under the Health Care Flexible Spending Account or the Limited Health Care Flexible Spending Account during the corresponding Grace Period, if a Grace Period is available under the Plan, as specified in the Plan Information Appendix.

**Sec. 4.3 Salary Reduction Credits to Accounts.** During an Election Period, each Participant may elect to have the Employer credit, if any, and salary reduction credit amounts allocated to the Participant's Accounts by entering into an Election on a form prescribed by and filed with the Employer, subject to the following:

(a) The Election shall specify the dollar amounts to be allocated to each of the Participant's Accounts for the Plan Year, and shall state the allocation of Employer credits, if any, and salary reduction credits. The Participant's Compensation for the Plan Year will be reduced by the amount of salary reduction credits the Participant elects to have credited to his Accounts under the Plan.

(b) Following an election, the Participant's Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account shall be credited with the full amount allocated by the Participant to his or her Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account for the entire Plan Year, which amount shall not exceed the dollar amount specified in the Plan Information Appendix. The Participant's Compensation shall be reduced in each payroll period by an amount equal to a pro rata share of the Participant's annual allocation of salary reduction credits to the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account.

(c) The Participant's Dependent Care Flexible Spending Account shall be credited in each payroll period with a pro rata share of the Participant's annual allocation to the Dependent Care Flexible Spending Account. A Participant's annual allocation to the Dependent Care Flexible Spending Account shall not exceed $5,000, or lesser amount specified in Appendix C, for any Plan Year. The Participant's Compensation shall be reduced in each payroll period by an amount equal to the amount of salary reduction credits credited to the Participant's Dependent Care Flexible Spending Account during that payroll period.

(d) The Participant's Individual Health Premium Account shall be credited in each payroll period with a pro rata share of the Participant's annual allocation to the Individual Health Premium Account. The Participant's Compensation shall be reduced in each payroll period by an amount equal to the amount of salary reduction credits credited to the Participant's Individual Health Premium Account during that payroll period.

(e) Subject to subsection 2.5(a), the Election shall be irrevocable for the Plan Year; provided, however, that during an Election Period described in Sec. 2.5(a) the Participant may enter into a new Election for the remainder of the Plan Year. Any such new Election which increases or decreases the amount credited, or to be credited during the remainder of the Plan Year, to the Participant's Accounts must be consistent with the change in status described in Sec. 2.5(a).

(f) No amount shall be credited after an employee ceases to be a Participant, except to the extent the Participant is eligible for, and has elected, continuation coverage as described in Section 4.10. Notwithstanding the foregoing, if participation in the Plan extends to the last day of the month in which a Termination of Employment occurred, if necessary, additional salary reduction contributions shall be taken from the Participant's final pay check to pay for the coverage provided during the period of time following the date on which the Participant's employment terminates.

**Sec. 4.4 Imputation of Income.**

(a) Coverage of non-Tax Dependents. To the extent a Participant elects coverage under a Benefit Plan for a dependent who is not the Participant's Spouse or Tax Dependent, the Plan Administrator may require the Participant to pay the cost of coverage for which the Participant is responsible on an after-tax basis up to the amount of the fair market value

of the coverage provided to such dependent. To the extent the cost of coverage for which the Participant is responsible exceeds that fair market value, the remaining cost of coverage may be paid pre-tax through this Plan. To the extent the cost of coverage for which the Participant is responsible is less than that fair market value, the excess of the fair market value over the after-tax payments shall be imputed as income to the Participant as the coverage is provided. In the alternative, the Plan Administrator may not require the Participant to pay the cost of coverage on an after-tax basis. In that case, the entire cost of coverage for the Benefit Plan for which the Participant is responsible shall be paid on a pre-tax basis through this Plan and the fair market value of the coverage for such dependent shall be imputed as income to the Participant as the coverage is provided (in accordance with the regulations under Section 125 of the Code). This imputation of income shall occur regardless of whether the cost of coverage is paid by salary reduction or allocation of available Employer credits.

(b) Group Term Life. The cost of group term life coverage on the Participant's life paid by the Employer will not be included in the Participant's gross income to the extent the face amount of the insurance contract(s) does not exceed $50,000, except as provided in Section 4.11. If the face amount of the insurance contract(s) exceeds $50,000, and the cost of the coverage is paid by the Employer, the value of the coverage in excess of $50,000 shall be imputed to the Participant as income in accordance with Section 79 of the Code and the regulations thereunder. For purposes of this limitation, coverage paid by the Participant on a pre-tax basis is considered "paid by the Employer." Under no circumstances shall the coverage on the life of persons covered through the Participant (e.g., the Participant's Spouse or children) be paid through this Plan.

**Sec. 4.5 Contributions to Health Savings Account.**

(a) Salary Reduction. A Participant may elect to have the Employer credit pre-tax salary reduction credit amounts to a Health Savings Account, if specified in the Plan Information Appendix. If specified in the Plan Information Appendix, only Participants who are enrolled in the high deductible health plan sponsored by the Employer are eligible for such contributions.

(b) Employer Credits. A Participant may also elect to have Employer credits contributed to a Health Savings Accounts through this Plan, if specified in the Plan Information Appendix. If specified in the Plan Information Appendix, only Participants who are enrolled in the high deductible health plan sponsored by the Employer are eligible for such contributions.

(c) Employer Contributions. The Employer may also make direct contributions to an Employee's Health Savings Account, which will be deemed to have been made through this Plan for purposes of the comparable contribution rules applicable under Code Section 223 and the nondiscrimination requirements applicable to this Plan, if specified in the Plan Information Appendix. If specified in the Plan Information Appendix, only Participants who are enrolled in the high deductible health plan sponsored by the Employer are eligible for such contributions.

Contributions to Health Savings Account are limited as provided in Code Section 223. The documents governing the Health Savings Account, including the trust or custodial agreement, set forth the terms of such account. The Employer may specify the Health Savings Account trustee or custodian to which contributions under the Plan will be contributed. To be eligible for Health Savings Account contributions, the Participant must: (1) be covered by a qualifying high deductible health plan (as that term is defined in Code Section 223); (2) not be claimed as another person's dependent for purposes of such person's federal income tax return; (3) not be covered by Medicare; and (4) not have any other health coverage except permitted insurance or permitted coverage. A Participant who has elected to contribute to the Health Care Flexible Spending Account under Appendix A for a Plan Year is not eligible to contribute salary reduction or Employer credits to, or receive Employer contributions to, a Health Savings Account during any month of the calendar year starting or ending in that Plan Year or the corresponding Grace Period, if elected in the Plan Information Appendix. Notwithstanding the foregoing, a Participant otherwise eligible to participate in a Health Savings Account, who has a Health Care Flexible Spending Account under Appendix A with a Grace Period, and whose Health Care Flexible Spending Account has a balance of zero at the end of the Plan Year, will be eligible to contribute salary reduction or Employer credits to, or receive Employer contributions to, a Health Savings Account beginning with the first month following the end of the Plan Year. Notwithstanding the foregoing, a Participant otherwise eligible to participate in a Health Savings Account, who has a Health Care Flexible Spending Account under Appendix A with a rollover, and whose Health Care Flexible Spending Account has a balance at the end of the Plan Year, will be eligible to contribute salary reduction or Employer credits to, or receive Employer contributions to, a Health Savings Account beginning with the first month following the end of the Plan Year if the rollover is provided to the Limited Health Care Flexible Spending Account or is waived as provided in Appendix A. A Participant contributing to, or receiving Employer contributions to, a Health Savings Account may participate in the Limited Health Care Flexible Spending Account under Appendix B but may not contribute to the Health Care Flexible Spending Account under Appendix A.

**Sec. 4.6 Payment of Premiums and Allocation to Accounts.** In accordance with a Participant's Election filed during an Election Period, the Employer shall pay the cost of coverage under the Benefit Plan, if any, contribute to a Health Savings Account, if specified in the Plan Information Appendix, and record an Account or Accounts, if any, for each Participant to which amounts are credited under Sec. 4.3 as designated by the Participant's Election, subject to the following:

(a) During each Election Period, the Participant shall designate the Account or Accounts to which the amount available pursuant to Secs. 4.2, if any, and 4.3 shall be credited. If amounts are to be credited to more than one Account, the Participant shall also designate the dollar amount to be credited to each Account. No more than the dollar amount specified in the Plan Information Appendix may be credited in any Plan Year to the Participant's Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account and no more than $5,000, or any lesser amount specified in Appendix C, may be credited in any year to the Participant's Dependent Care Flexible Spending Account.

(b) Amounts that are allocated to a Dependent Care Flexible Spending Account or an Individual Health Premium Account pursuant to subsection (a) shall be credited to the Dependent Care Flexible Spending Account or an Individual Health Premium Account as of the day that the wages or salary, which were foregone in lieu of the amount to be credited, would otherwise have been paid. The full amount that is allocated to a Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account for the entire Plan Year shall be credited to the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account as of the first day of the Plan Year or, if

participation in the Plan begins after the first day of the Plan Year, the first day of the Participant's participation in the Plan.

(c) Amounts credited to Accounts are for bookkeeping purposes only. A Participant's claim against the Employer for benefits from the Participant's Accounts is that of a general creditor and is not secured. No assets relating to such Accounts are segregated from other assets of the Employer. No interest or other earnings shall be credited to or with respect to any Account. Nothing in this Plan is intended to require the establishment of a trust.

(d) If any amounts remain credited to an Account after the last day of the Plan Year or, if elected in the Plan Information Appendix, the last day of the corresponding Grace Period, the credit balance shall be cancelled; provided, however, that benefit payments for reimbursement of expenses incurred on or before the last day of the Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period, may be charged against amounts credited on said date if a claim for reimbursement is filed with the Plan Administrator (or its designee) within ninety (90) days following the end of the Plan Year. If any amounts remain credited to an Account after the last day of the Plan Year the credit balance shall be cancelled; provided, however, that a rollover of an Account may occur as provided in Appendices A and B if elected in the Plan Information Appendix. Terminated Participants must submit claims for expenses incurred before their termination within ninety (90) days following the date on which participation terminates.

**Sec. 4.7 Payments Charged Against Accounts.** Payments under Appendix A, B, C, or D to the Plan shall be charged against the amounts credited to the appropriate Account for the Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period in which the reimbursable expense is incurred, subject to the following:

(a) Payments may not exceed the amount credited to the Participant's Account at the time the payments are made. Benefits for eligible expenses incurred in one Plan Year may not be paid with respect to amounts credited to another Plan Year; except that (i) eligible expenses incurred during the Grace Period, if elected in the Plan Information Appendix, that corresponds with the Plan Year will be eligible for reimbursement pursuant to the terms of the Plan; or (ii) amounts rolled over to the following Plan Year (if rollovers are elected in the Plan Information Appendix) may be used to reimburse expenses from the prior Plan Year that are submitted during the applicable claim run-out period. If a Participant incurs an expense during a Plan Year that coincides with a Grace Period, the Participant shall be responsible for indicating in the appropriate section of the claim reimbursement form whether the claim relates to the current Plan Year or the Grace Period for the prior Plan Year.

(b) The Plan Administrator requires the Participant to verify expenses for which the Participant is seeking payment or reimbursement in any manner that the Plan Administrator deems appropriate. The Plan Administrator shall have the authority to review expenses submitted for reimbursement and to make the final decision whether a particular benefit claim is eligible for reimbursement by the Plan. However, the Plan Administrator may also delegate such questions to an independent review agency such as an insurance company or other service provider.

(c) Claims may be submitted at any time subject to the claim filing deadlines specified in Section 4.6(d). Payments will be made as soon as administratively possible upon receipt of the claim.

(d) The Employer shall make payments to the Participant.

**Sec. 4.8 Termination of Participation.** Any balance remaining in a Participant's Account after he ceases to be a Participant and after all benefits to which he is entitled have been paid shall be forfeited.

**Sec. 4.9 Payments Following a Participant's Death.** The Plan Administrator shall apply amounts credited to a deceased Participant's Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account for the Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period in which his death occurred to pay eligible expenses incurred during the portion of the Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period prior to the Participant's death. The Plan Administrator shall apply amounts credited to a deceased Participant's Dependent Care Flexible Spending Account and Individual Health Premium Account for the Plan Year in which his death occurred to pay eligible expenses incurred during the Plan Year, whether incurred before or after the Participant's death. Any amount remaining in the Accounts with respect to that Plan Year after such reimbursements have been made shall be forfeited.

**Sec. 4.10 Continuation Coverage.** The Plan shall provide any continuation of Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account coverage that may be required by Sections 2201 through 2208 of the Public Health Services Act ("PHSA"), or the regulations thereunder, provided that the Participant pays to the Employer on an after-tax basis the cost of any such coverage in effect following the qualifying event. For purposes of providing continuation coverage, coverage under the Health Care Flexible Spending Account or the Limited Health Care Flexible Spending Account is deemed to be available only to the Participant for reimbursement of the Participant's medical expenses, which may include medical expenses of the Participant's Spouse and Tax Dependents, and is deemed not to be available to the Participant's Spouse or Tax Dependent children. If the Health Care Flexible Spending Account and/or the Limited Health Care Flexible Spending Account is eligible for the special limited continuation coverage obligation under Treasury Regulation Section 54.4980B-2, Q/A-8, continuation coverage shall end not later than the last day of the Plan Year or, if elected in the Plan Information Appendix, the last day of the Grace Period in which the qualifying event under PHSA Sections 2201 through 2208 occurred, and shall be provided only if the Participant's Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account has a positive balance on the date the qualifying event occurred, taking into account all eligible expenses incurred prior to that date, whether or not a claim has been submitted prior to that date. No such continuation of coverage is provided with respect to a Dependent Care Flexible Spending Account or the Individual Health Premium Account. The Plan shall also provide any continuation of coverage that may be required by the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA"), provided that the Participant pays to the Employer the appropriate portion of the cost of that coverage pursuant to applicable federal regulations. The Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage.

**Sec. 4.11 Discrimination Prohibited.** The Plan shall not be operated in such a manner as to discriminate in favor of highly compensated individuals or Participants, and shall be operated in compliance with any applicable Internal Revenue Service regulations regarding such discrimination, including, but not limited to the provisions of Code Sections 79, 105(h), 125, and 129. The Plan Administrator reserves the right to change (1) Plan provisions regarding limitations on benefit availability or (2) Elections to the extent such changes are required to avoid such discrimination. In the event that Elections by highly compensated employees for credits to Dependent Care Flexible Spending Accounts

would cause the limits of Code Section 129(d)(8) to be exceeded for a Plan Year, the Plan Administrator shall reduce the credits for that year for such individuals, beginning with the highest dollar amount of credit, to the extent necessary to satisfy said limits. If a Participant has already received benefits with respect to credits that are to be reduced pursuant to the previous sentence, such benefits shall be treated as taxable income to the Participant.

**Sec. 4.12 Family and Medical Leave Act.** The Plan shall also provide any continuation of coverage that may be required by the Family and Medical Leave Act of 1993 ("FMLA"), provided the Employer is subject to FMLA. Any continuation of coverage required under the FMLA shall be provided in accordance with the Employer's FMLA policy, which is hereby incorporated by reference.

**Sec. 4.13 Provision of Protected Health Information to the Employer.** The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") described in this Section are effective for this Plan on April 14, 2004 (or the required compliance date for this Plan, if different).

(a) Permitted Uses and Disclosures. In accordance with HIPAA and the applicable regulations issued and effective thereunder (the "HIPAA Privacy Rules"), the Plan may disclose Protected Health Information ("PHI") (as defined in 45 C.F.R. Section 160.103) related to the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account to the Employer in order for the Employer to carry out Plan administration functions that the Employer performs consistent with the provisions of subsections (b), (c), and (d) below. The Plan may not:

(1) Disclose or permit an insurance company, insurance service, insurance organization, or HMO to disclose PHI to the Employer unless the HIPAA Privacy notice covering the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account contains a statement describing such disclosure.

(2) 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, unless otherwise authorized by the individual who is the subject of the PHI or required by the HIPAA Privacy Rules.

(b) Conditions of Disclosure. The Plan may disclose PHI related to the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account to the Employer as described in subsection (a) only upon receipt of a certification by the Employer that the Plan has been amended to incorporate the following provisions and only if the Employer agrees to:

(1) Not use or further disclose the PHI other than as permitted or required by the Plan's controlling documents or as required by law.

(2) 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.

(3) 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.

(4) Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided herein, if and when the Employer becomes aware of such inconsistent use or disclosure.

(5) Authorize the Plan to make PHI available to individuals, in accordance with HIPAA Privacy Rules and consistent with the HIPAA Privacy policy applicable to the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account.

(6) Authorize the Plan to make PHI available to individuals for amendment and to incorporate into PHI any such amendments, in accordance with the HIPAA Privacy Rules and consistent with the HIPAA Privacy policy applicable to the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account.

(7) Authorize the Plan to make available the information required to provide an accounting of disclosures, in accordance with the HIPAA Privacy Rules and consistent with HIPAA Privacy policy applicable to the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account.

(8) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with the HIPAA Privacy Rules.

(9) If feasible, 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.

(10) Ensure that the adequate separations described in subsection (c) below are established.

(c) Adequate Separations. The Employer shall ensure that the following adequate separations are established between the Plan and the Employer:

(1) Only the privacy officer and other persons under the control of the Employer and specifically designated by the Employer shall be given access to PHI related to the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account (the "Group").

(2) Access to and use of PHI by the Group shall be restricted to the Plan administration functions that the Employer performs for the Plan's Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account.

(3) Non-compliance by the Group shall be resolved by applying the disciplinary measures specified in the Plan's HIPAA Privacy sanctions procedures.

(d) Security of Electronic Protected Health Information. Effective April 21, 2006 (or the required compliance date for this Plan, if different) and in accordance with the Security

Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Sections 160 and 164, the Employer agrees to reasonably and appropriately safeguard Electronic Protected Health Care Information ("EPHI") (as defined in 45 C.F.R. Section 160.103) created, received, maintained or transmitted to or by the Employer on behalf of Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account and shall:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that it creates, receives, maintains or transmits on behalf of the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account.

(2) Ensure that the separations described in subsection (c) above are supported by reasonable and appropriate security measures.

(3) Ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect EPHI.

(4) Report to the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account any security incident of which it becomes aware.

## ARTICLE V

## PLAN ADMINISTRATION

**Sec. 5.1 Duties of the Plan Administrator.** The Plan shall be administered and interpreted by the Plan Administrator. In carrying out its Plan responsibilities, the Plan Administrator shall have full discretionary authority to make any and all factual determinations necessary to determine eligibility for benefits or the amount of any benefits and full discretionary authority to construe the terms of the Plan. It is intended that the Plan Administrator have discretion to the fullest extent permitted by law and that the Plan Administrator's exercise of its discretion be given deference to the greatest extent allowed under the law. This discretion includes, but is not limited to, the authority to adopt any rules, regulations, forms, or computations that the Plan Administrator deems necessary to administer the Plan. The Plan Administrator may delegate its duties to one or more officers or employees of the Employer, or to individuals or entities independent of the Employer. The Plan Administrator shall establish a claims procedure pursuant to which claims under the Plan shall be determined.

**Sec. 5.2 Liability of Administrative Personnel.** Neither the Plan Administrator nor any of its employees shall be liable for any loss due to an error or omission in the administration of the Plan unless the loss is due to gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character with like aims.

**Sec. 5.3 Plan Not a Contract of Employment.** The Plan is not an employment agreement and does not assure the continued employment of any employee or Participant for any time or period.

**Sec. 5.4 Plan Benefits are Unsecured.** No Participant shall, by virtue of the Plan, have any interest in any specific asset or assets of the Employer. A Participant has only an unsecured contract right to receive payments in accordance with the Plan.

**Sec. 5.5 Plan Benefits May Not Be Assigned.** No Participant may assign, pledge, or otherwise dispose of any benefit under the Plan prior to actual receipt thereof, unless a Benefit Plan specifically allows such assignment.

**Sec. 5.6 Tax Consequences.** The Employer does not make any representation or guarantee to any Participant or dependent that any amounts deducted from a Participant's pay or benefits paid under this Plan will be excludable from the Participant's gross income for federal or state income or other tax purposes, or that any particular federal or state treatment will apply to the Participant. Each Participant is solely responsible for determining whether payments under this Plan are excludable from the Participant's gross income for federal and state income tax purposes, and shall notify the Employer if the Participant has reason to believe that any such payment is not excludable.

**Sec. 5.7 Indemnification of the Employer by Participants.** If a Participant receives any payment under this Plan that is not excludable from gross income for tax purposes, the Participant shall reimburse the Employer for any liability it may incur due to failure to withhold federal or state income taxes or FICA taxes from such payment, but not to exceed the amount of taxes the Participant would have owed if this Plan did not exist.

## ARTICLE VI

## AMENDMENT AND TERMINATION

**Sec. 6.1 Amendment and Termination.** The Employer, or its authorized representative, may amend or terminate this Plan at any time by action of its governing body. Such amendment or termination shall be made in writing. Such amendment or termination shall not affect any right to benefits that accrued prior to such amendment. For example, if the Plan is terminated, any amounts credited to Accounts on the date of termination with respect to a Participant shall be applied to pay eligible expenses incurred before the termination date. Any balance remaining after all such payments have been made shall be forfeited.

IN WITNESS WHEREOF, the Employer, through its duly authorized officer, hereby executes

- ❑ the Plan
- ❑ the amendment and restatement of the Plan

as set forth herein this _____ day of _____, _____, effective as of the date specified herein.

Employer

By: _____

Its: _____

## APPENDIX A

## HEALTH CARE FLEXIBLE SPENDING ACCOUNT

**A-1 Benefits.** Participants who contribute to Health Savings Accounts, or have contributions made on their behalf, during any month of the taxable year starting or ending in the Plan Year are not eligible to participate in this Appendix A for that Plan Year but may elect to participate in Appendix B. Participants who elect to participate in Appendix B are not eligible to participate in this Appendix A. A Participant is entitled to reimbursement from the Participant's Health Care Flexible Spending Account for Medical Expenses incurred during the Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period on behalf of the Participant or the Participant's Spouse or Tax Dependents, subject to the following:

(a) "Medical Expense" means expenses for medical care, including dental and vision care, as defined in Code Section 213, but only to the extent such expenses are not reimbursed by insurance or from some other source; provided, however, that "Medical Expenses" shall not include the expense of premiums for accident or health insurance. "Medical Expenses" also shall not include expenses for cosmetic procedures. As a condition to receiving benefits under the Plan, a Participant shall make every reasonable effort to obtain reimbursement of medical expenses from other available sources. "Medical Expenses" covered by the Plan includes ambulance or other transportation costs essential to medical care but does not include other transportation costs. Over-the-counter drugs and medicines shall be "Medical Expenses" only if they are prescribed as required by Section 106(f) of the Code.

(b) "Spouse" means an individual who is: (i) legally married to a Participant (under applicable state law), and (ii) treated as a "Spouse" under the applicable section of the Code. Medical Expenses with respect to a Spouse shall cease to be considered the Participant's Medical Expenses upon the dissolution of marriage to the Participant, except to the extent such expenses were incurred prior to the date of dissolution.

(c) "Tax Dependents" means an individual (other than the Participant and the Participant's Spouse) with respect to whom amounts expended for medical care are excluded from the Participant's gross income under Section 105(b) of the Code, as amended.

(d) Medical Expenses incurred by the Participant, the Participant's Spouse, and or the Participant's Tax Dependents prior to the date the individual becomes a Participant under the Plan shall not be eligible for reimbursement under the Plan. Expenses are considered to be "incurred" when the service giving rise to the expense is rendered.

(e) A Participant shall not be entitled to reimbursement for Medical Expenses incurred during a particular Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period, except to the extent there are amounts credited to the Participant's Account for that Plan Year against which benefit payments may be charged pursuant to Sec. 4.7. In any event, no more than the dollar amount specified in the Plan Information Appendix may be reimbursed to a Participant for a Plan Year.

(f) Claims for reimbursement of Medical Expenses incurred during a Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period, must be submitted to the Plan Administrator, or its designee, within ninety (90) days following the end of the Plan Year or, if earlier, within ninety (90) days following the date on which participation ends.

(g) Claims under this Appendix shall be made in accordance with rules established by the Plan Administrator. In addition, if elected in the Plan Information Appendix, claims for reimbursement may be made by use of an electronic payment card, subject to the following conditions:

(1) The electronic payment card may be used only while a Participant is employed by the Employer.

(2) The balance of the electronic payment card shall be limited to the amount in the applicable Participant's Health Care Flexible Spending Account.

(3) A Participant must certify in writing prior to issuance of the electronic payment card that:

(i) the electronic payment card will be used only for eligible expenses that have not been reimbursed under any other plan covering similar benefits; and

(ii) the Participant will not seek reimbursement for any expense paid with the electronic payment card under any other plan covering benefits.

The electronic payment card shall include a statement providing that each use of the card shall constitute a reaffirmation of the certification.

(4) For eligible expenses, the electronic payment card may be used only at merchants who are health care providers (e.g., doctor's office, hospital, etc.) or other merchants identified in applicable IRS guidance.

(5) Each time the electronic payment card is used, a Participant shall obtain and retain a third party statement from the health care provider containing the information necessary to substantiate that the expense paid by the card was an eligible expense.

(6) Claims (other than claims subject to paragraph (7) below) shall be substantiated in one of the following manners:

(i) The Participant shall provide, upon request by the Plan Administrator (or its designee), the third party statement with respect to the claim.

(ii) For eligible expenses, the payment was made to a merchant who is a health care provider and it matches a specific co-payment the Participant has under a group medical or group dental plan sponsored by the Employer or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment.

(iii) For eligible expenses, the payment was made to a merchant who is a health care provider and is for an expense with the same amount, duration, and health care provider as a previously approved expense under this Plan.

(iv) For eligible expenses, the payment was made to a merchant who is a health care provider and the electronic claim file with respect to the

expense is accompanied by an electronic or written confirmation from the health care provider that identifies the nature of the expense and verifies that the expense is an eligible expense.

(v) For eligible expenses, the electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.

(7) Claims for over-the-counter drugs and medicines (other than insulin) shall be substantiated in accordance with IRS Notice 2011-5 and/or other applicable IRS guidance.

(8) A Participant shall repay the Plan for a payment with respect to any claim not substantiated (and therefore not eligible for reimbursement) as required above. The Plan shall handle unsubstantiated claims as required under the Code and applicable regulations.

(9) The use of an electronic payment card does not constitute a "claim" under the claims procedures.

(h) A Participant may request, in writing on a form provided by the Plan Administrator, a "Qualified Reservist Distribution" from the Participant's Health Care Flexible Spending Account if: (1) the Participant is a member of the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service; and (2) the Participant has been ordered or called to active duty for either (i) at least 180 days, or (ii) an indefinite period of time. Such request must be made on or after the date of the order or call to active duty and before the last day of the Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period. A copy of the order or call to duty must accompany the form. The amount available to the Participant as a Qualified Reservist Distribution shall be the amount contributed to the Health Care Flexible Spending Account as of the date of the request minus any reimbursements of Medical Expenses provided under the Health Care Flexible Spending Account as of that date. Such distributions shall be included in the Participant's taxable income and shall be subject to normal wage withholding requirements to the extent required by law. If a balance remains in the Participant's account following the Qualified Reservist Distribution, the Participant may continue to submit claims for reimbursement.

(i) Notwithstanding the rule that the Health Care Flexible Spending Account shall reimburse only Medical Expenses incurred during the Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period, pursuant to and in accordance with the regulations under Code Section 125, if elected in the Plan Information Appendix, the Plan may reimburse Medical Expenses for orthodontia care in advance.

(j) If elected in the Plan Information Appendix, a limited rollover of Health Care Flexible Spending Account balances from Plan Year to Plan Year will be provided in accordance with the following conditions and restrictions:

(1) The amount that may be rolled over is limited to the lesser of (i) $500 or (ii) the balance of the Participant's Health Care Flexible Spending Account. The balance

of a Participant's Health Care Flexible Spending Account shall be determined upon expiration of the claims run-out period provided in paragraph (f) above.

(2) Notwithstanding the requirement referenced in subparagraph (1) above, the balance of the Participant's Health Care Flexible Spending Account as of midnight on the last day of the Plan Year, up to the amount specified in subparagraph (1) above, shall be rolled over and available to reimburse Medical Expenses incurred on and after the first day of the new Plan Year. The Claims Administrator will administer claims submitted during the claims run-out period (including allocating claims between the Participant's rollover balance and the Participant's election for the new Plan Year (if any)) in a manner consistent with applicable law (including regulatory guidance).

(3) In general, a rollover made in accordance with this paragraph (j) shall occur within the Health Care Flexible Spending Account. However, if the Plan includes a Limited Health Care Flexible Spending Account and unless otherwise prohibited under applicable law (including regulatory guidance), a Participant entitled to a Health Care Flexible Spending Account rollover in accordance with this paragraph (j) shall receive the rollover to a Limited Health Care Flexible Spending Account if: (i) the Participant enrolls in the Limited Health Care Flexible Spending Account for the following Plan Year, or (ii) the Participant directs the Plan Administrator, by no later than the last day of the Plan Year from which the rollover is to be made and in accordance with procedures adopted by the Plan Administrator, to make the rollover to the Limited Health Care Flexible Spending Account.

(4) In general, a rollover made in accordance paragraph (j) shall occur automatically. However, unless otherwise prohibited under applicable law (including regulatory guidance), a Participant entitled to a Health Care Flexible Spending Account rollover in accordance with this paragraph (j) may elect, by no later than the last day of the Plan Year from which the rollover is to be made and in accordance with procedures adopted by the Plan Administrator, to waive the rollover. Such right to waive the rollover shall be available only if (i) the Plan does not include a Limited Health Care Flexible Spending Account and (ii) the purpose of the waiver is to maintain the Participant's (or the Participant's Spouse's) eligibility to make or receive HSA contributions.

(5) Unless otherwise required under applicable law (including regulatory guidance), a rollover of a Health Care Flexible Spending Account balance shall be available only to individuals who are eligible to make elections under the Health Care Flexible Spending Account as of the first day of the Plan Year to which the rollover will be made (regardless of whether the individual actually elects to participate in the Plan).

(6) A rollover shall not count against the maximum annual amount a Participant may contribute to his or her Health Care Flexible Spending Account as specified in the Plan Information Appendix.

(k) The Health Care Flexible Spending Account is intended to be an excepted benefit under HIPAA. Accordingly, the preventative care mandate of the Patient Protection and Affordable Care Act, as amended, does not apply to the Plan.

## APPENDIX B

## LIMITED HEALTH CARE FLEXIBLE SPENDING ACCOUNT

**B-1 Benefits.** Participation in this Appendix B for each Plan Year is limited to Participants who contribute to Health Savings Accounts, or have contributions made on their behalf (or have a Spouse who contributes to a Health Savings Account or has contributions made on his/her behalf), during any month of the taxable year starting or ending in the Plan Year. Participants who elect to participate in Appendix A are not eligible to participate in this Appendix B. A Participant is entitled to reimbursement from the Participant's Limited Health Care Flexible Spending Account for Eligible Expenses incurred during the Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period on behalf of the Participant or the Participant's Spouse or Tax Dependents, subject to the following:

(a) "Eligible Expense" means expenses identified in the Plan Information Appendix, but only to the extent such expenses (i) constitute expenses for medical care (including dental and vision care) as defined in Code Section 213, (ii) constitute permitted coverage within the meaning of Code Section 223(c), Rev. Rule 2004-45, and other applicable IRS guidance, and (iii) are not reimbursed or reimbursable by insurance or from some other source; provided, however, that "Eligible Expenses" shall not include the expense of premiums for accident or health insurance. "Eligible Expenses" also shall not include expenses for cosmetic procedures. As a condition to receiving benefits under the Plan, a Participant shall make every reasonable effort to obtain reimbursement of Eligible Expenses from other available sources. Over-the-counter drugs and medicines shall be "Eligible Expenses" only if they are prescribed as required by Section 106(f) of the Code.

(b) "Spouse" means an individual who is: (i) legally married to a Participant (under applicable state law), and (ii) treated as a "Spouse" under the applicable section of the Code. Eligible Expenses with respect to a Spouse shall cease to be considered the Participant's Eligible Expenses upon the dissolution of marriage to the Participant, except to the extent such expenses were incurred prior to the date of dissolution.

(c) "Tax Dependents" means an individual (other than the Participant and the Participant's Spouse) with respect to whom amounts expended for medical care are excluded from the Participant's gross income under Section 105(b) of the Code, as amended.

(d) Eligible Expenses incurred during the Plan Year by the Participant, the Participant's Spouse, or the Participant's Tax Dependents prior to the date the individual becomes a Participant under the Plan shall not be eligible for reimbursement under the Plan. Expenses are considered to be "incurred" when the service giving rise to the expense is rendered.

(e) A Participant shall not be entitled to reimbursement for Eligible Expenses incurred during a particular Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period, except to the extent there are amounts credited to the Participant's Account for that Plan Year against which benefit payments may be charged pursuant to Sec. 4.7. In any event, no more than the dollar amount specified in the Plan Information Appendix may be reimbursed to a Participant for a Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period.

(f) Claims for reimbursement of Eligible Expenses incurred during a Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period, must be submitted to the Plan Administrator, or its designee, within ninety (90) days following the end of the

Plan Year or, if earlier, within ninety (90) days following the date on which participation ends.

(g) Claims under this Appendix shall be made in accordance with rules established by the Plan Administrator. In addition, if elected in the Plan Information Appendix, claims for reimbursement may be made by use of an electronic payment card, subject to the following conditions:

(1) The electronic payment card may be used only while a Participant is employed by the Employer.

(2) The balance of the electronic payment card shall be limited to the amount in the applicable Participant's Limited Health Care Flexible Spending Account.

(3) A Participant must certify in writing prior to issuance of the electronic payment card that:

(i) the electronic payment card will be used only for eligible expenses that have not been reimbursed under any other plan covering similar benefits; and

(ii) the Participant will not seek reimbursement for any expense paid with the electronic payment card under any other plan covering benefits.

The electronic payment card shall include a statement providing that each use of the card shall constitute a reaffirmation of the certification.

(4) For eligible expenses, the electronic payment card may be used only at merchants who have dental and vision merchant category codes.

(5) Each time the electronic payment card is used, a Participant shall obtain and retain a third party statement from the health care provider containing the information necessary to substantiate that the expense paid by the card was an eligible expense.

(6) Claims (other than claims subject to paragraph (7) below) shall be substantiated in one of the following manners:

(i) The Participant shall provide, upon request by the Plan Administrator (or its designee), the third party statement with respect to the claim.

(ii) For eligible expenses, the payment was made to a merchant who is a dental or vision provider and it matches a specific co-payment the Participant has under a group dental or group vision plan sponsored by the Employer or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment.

(iii) For eligible expenses, the payment was made to a merchant who is a dental or vision provider and is for an expense with the same amount, duration, and dental or vision provider as a previously approved expense under this Plan.

(iv) For eligible expenses, the payment was made to a merchant who is a dental or vision provider and the electronic claim file with respect to the expense is accompanied by an electronic or written confirmation from the dental or vision provider that identifies the nature of the expense and verifies that the expense is an eligible expense.

(v) For eligible expenses, the electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute an Eligible Expense.

(7) Claims for over-the-counter drugs and medicines (other than insulin) shall be substantiated in accordance with IRS Notice 2011-5 and/or other applicable IRS guidance.

(8) A Participant shall repay the Plan for a payment with respect to any claim not substantiated (and therefore not eligible for reimbursement) as required above. The Plan shall handle unsubstantiated claims as required under the Code and applicable regulations.

(9) The use of an electronic payment card does not constitute a "claim" under the claims procedures.

(h) A Participant may request, in writing on a form provided by the Plan Administrator, a "Qualified Reservist Distribution" from the Participant's Limited Health Care Flexible Spending Account if: (1) the Participant is a member of the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service; and (2) the Participant has been ordered or called to active duty for either (i) at least 180 days, or (ii) an indefinite period of time. Such request must be made on or after the date of the order or call to active duty and before the last day of the Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period. A copy of the order or call to duty must accompany the form. The amount available to the Participant as a Qualified Reservist Distribution shall be the amount contributed to the Limited Health Care Flexible Spending Account as of the date of the request minus any reimbursements of Eligible Expenses provided under the Limited Health Care Flexible Spending Account as of that date. Such distributions shall be included in the Participant's taxable income and shall be subject to normal wage withholding requirements to the extent required by law. If a balance remains in the Participant's account following the Qualified Reservist Distribution, the Participant may continue to submit claims for reimbursement.

(i) Notwithstanding the rule that the Limited Health Care Flexible Spending Account shall reimburse only Eligible Expenses incurred during the Plan Year or, if elected in the Plan Information Appendix, the corresponding Grace Period, pursuant to and in accordance with the regulations under Code Section 125, if elected in the Plan Information Appendix, the Plan may reimburse Eligible Expenses for orthodontia care in advance.

(j) If elected in the Plan Information Appendix, a limited rollover of Limited Health Care Flexible Spending Account balances from Plan Year to Plan Year will be provided in accordance with the following conditions and restrictions:

(1) The amount that may be rolled over is limited to the lesser of (i) $500 or (ii) the balance of the Participant's Limited Health Care Flexible Spending Account. The balance of a Participant's Limited Health Care Flexible Spending Account shall be determined upon expiration of the claims run-out period provided in paragraph (f) above.

(2) Notwithstanding the requirement referenced in subparagraph (1) above, the balance of the Participant's Limited Health Care Flexible Spending Account as of midnight on the last day of the Plan Year, up to the amount specified in subparagraph (1) above, shall be rolled over and available to reimburse Eligible Expenses incurred on and after the first day of the new Plan Year. The Claims Administrator will administer claims submitted during the claims run-out period (including allocating claims between the Participant's rollover balance and the Participant's election for the new Plan Year (if any)) in a manner consistent with applicable law (including regulatory guidance).

(3) Unless otherwise required under applicable law (including regulatory guidance), a rollover of a Limited Health Care Flexible Spending Account balance shall be available only to individuals who are eligible to make elections under the Limited Health Care Flexible Spending Account as of the first day of the Plan Year to which the rollover will be made (regardless of whether the individual actually elects to participate in the Plan).

(4) A rollover shall not count against the maximum annual amount a Participant may contribute to his or her Limited Health Care Flexible Spending Account as specified in the Plan Information Appendix.

(k) The Limited Health Care Flexible Spending Account is intended to be an excepted benefit under HIPAA. Accordingly, the preventative care mandate of the Patient Protection and Affordable Care Act, as amended, does not apply to the Plan.

## APPENDIX C

## DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

**C-1 Purpose.** This Appendix C constitutes a separate written dependent care assistance plan under Code Section 129. Its purpose is to provide Participants with dependent care assistance which meets the requirements of Code Section 129(d)(2) through (7).

**C-2 Definitions.** The following defined terms are used in this Appendix C:

(a) "Qualifying Individual" has the meaning of that term assigned by Code Section 21(b)(1) and the regulations thereunder and includes "Type A Qualifying Individuals" and "Type B Qualifying Individuals".

(b) "Type A Qualifying Individual" means an individual who is under age thirteen (13) and who is a qualifying child within the meaning of Section 152.

(c) "Type B Qualifying Individual" means any Dependent other than a Type A Qualifying Individual of the Participant, or any Spouse of the Participant, who is physically or mentally incapable of caring for himself or herself, and who has the same principal abode as the taxpayer for more than one half of the taxable year.

(d) A "Dependent" of the Participant is any person defined as such under Code Section 152, determined without regard to Code Sections 152(b)(1), (b)(2), and (d)(1)(B).

(e) "Employment-Related Expenses" has the meaning assigned to that term by Code Section 21(b)(2) and the regulations thereunder. Employment-Related Expenses includes only expenses incurred to enable the Participant to be gainfully employed during any period during which the Participant has one or more Qualifying Individuals. Employment-Related Expenses includes the following expenses for household services and for care of a Qualifying Individual:

(1) All such expenses incurred within the Participant's household.

(2) All such expenses, subject to the last sentence of this paragraph (e), incurred outside the Participant's household for the care of a Type A Qualifying Individual or for the care of a Type B Qualifying Individual who regularly spends at least eight (8) hours a day in the Participant's household.

Any expenses incurred for services provided outside the Participant's household by a Dependent Care Center which provides care for more than six (6) individuals, excluding individuals who reside there, shall be included as Employment-Related Expenses only if the Dependent Care Center complies with all applicable state and local laws and regulations.

(f) "Dependent Care Center" means any facility outside the Participant's household which receives a fee, payment or grant for providing services for any of the individuals, regardless of whether the facility is operated for profit.

(g) "Spouse" means an individual who is: (i) legally married to a Participant (under applicable state law), and (ii) treated as a "Spouse" under the applicable section of the Code.

**C-3 Benefits.** A Participant is entitled to reimbursement for Employment-Related Expenses the Participant has incurred during the Plan Year, subject to the following:

(a) Employment-Related Expenses incurred during the Plan Year by the Participant prior to the date the Participant becomes a Participant under the Plan shall not be eligible for reimbursement under the Plan. Such Expenses shall be considered to be incurred at the time the service is rendered which gives rise to the expense.

(b) A Participant shall not be reimbursed for Employment-Related Expenses incurred during a particular Plan Year except to the extent there are amounts credited to the Participant's Dependent Care Flexible Spending Account for that Plan Year against which reimbursements may be charged pursuant to Sec. 4.7.

(c) A Participant shall not be reimbursed for amounts paid to any of the following individuals for dependent care services rendered by such individual: (i) a child of the Participant who has not attained age nineteen (19) as of the close of the taxable year in which the child performed services; (ii) a Dependent of the Participant with respect to whom a deduction under Code Section 151(c) is allowable to the Participant or the Participant's Spouse for the taxable year in which the Dependent performed services, (iii) an individual who is the Spouse of the Participant at any time during the taxable year; or (iv) the parent of the Participant's child who is a Qualifying Individual.

(d) The amount of benefits paid to a Participant during the taxable year shall not exceed the lesser of $5,000 ($2,500 in the case of a Participant who is a married individual filing a separate tax return) or whichever of the following limitations is applicable:

(1) In the case of a Participant who is not married at the close of the taxable year, the Compensation paid to the Participant for that taxable year, reduced by any salary reduction under this Plan.

(2) In the case of a Participant who is married on the last day of the taxable year, the lesser of (i) the amount in (1) above or (ii) the "earned income" of the employee's Spouse for such taxable year (as defined in Code Section 32(c)(2)) other than any amount paid by an employer for dependent care assistance under this or any other Plan. However, for each month that the Spouse is a full-time student at an educational institution or is incapable of caring for himself or herself the Spouse will be deemed to have earned income of not less than whichever of the following amounts is applicable:

(A) $250, if there is one Qualifying Individual with respect to the Participant during that taxable year.

(B) $500, if there are two or more Qualifying Individuals with respect to the Participant during that taxable year.

(e) Claims for reimbursement of Employment-Related Expenses incurred during the Plan Year must be submitted to the Plan Administrator, or its designee, within ninety (90) days following the end of the Plan Year.

(f) Claims under this Appendix shall be made in accordance with rules established by the Plan Administrator.

(g) With the exception of two parents who file income taxes jointly, only one person is entitled to treat the child as a Qualifying Individual for the purpose of dependent care flexible spending account programs. Where multiple people are involved, there are two special rules to determine which person is entitled to treat the child as a Qualifying Individual.

(1) Divorced or Separated Parents, or Parents Living Apart. If a child's parents are divorced, legally separated, separated pursuant to a written agreement, or live apart at all times during the last six (6) months of the calendar year, a special rule applies if: (i) the child is under age 13 or is mentally or physically unable to care for himself or herself; (ii) the child receives more than 50% of his or her support from the parents (in aggregate); and (iii) the child resides with the parents (in aggregate) for more than 50% of the year. In such situations, the child is the Qualifying Individual of the custodial parent even if the custodial parent has released the right to claim the child as a dependent. The custodial parent is the parent identified in Section 152(e) of the Code (i.e., generally the parent with whom the child resides for the greater number of nights during the calendar year or, if the child resides with both parents for an equal number of nights, the parent with the higher adjusted gross income for the year).

(2) Two or More Persons Claiming a Child as a Qualifying Individual. If the special rule described above regarding divorce, etc. does not apply, the special tie-breaker rules of Section 152(c)(4) of the Code may apply. If an individual is a qualifying child (as defined in Section 152 of the Code) with respect to more than one person, then:

(i) If both persons are the individual's parents and they file a joint federal income tax return, the child is the Qualifying Individual of both parents.

(ii) If both persons are the individual's parents and they file separate federal income tax returns, then the child is the Qualifying Individual of the parent with whom the child resided for the longest period of time during the calendar year (or, if child resides with both parents for the same amount of time during the year, the parent with the highest adjusted gross income for the year). However, if that parent (i.e., the custodial parent or the parent with the highest adjusted gross income) does not claim the child as a qualifying child (as defined in Section 152 of the Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other parent (i.e., the non-custodial parent or the parent with the lowest adjusted gross income). This is the one person that is entitled to treat the child as a Qualifying Individual.

(iii) If one person is the individual's parent and the other is not, the child is the Qualifying Individual of the parent. However, if the parent does not claim the child as a qualifying child (as defined in Section 152 of the Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the non-parent). This is the one person that is entitled to treat the child as a Qualifying Individual.

(iv) If neither person is the individual's parent, the child is the Qualifying Individual of the person with the highest adjusted gross income for the year in question. However, if that person does not claim the child as a qualifying child (as defined in Section 152 of the Code) for any purpose (i.e., a dependent care expense reimbursement program, the Earned Income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the person with the lowest adjusted gross income). This is the one person that is entitled to treat the child as a Qualifying Individual.

## APPENDIX D

## INDIVIDUAL HEALTH PREMIUM ACCOUNT

**D-1 Purpose.** This Appendix D constitutes a separate written plan for purposes of Sections 105 and 106 of the Code. Its purpose is to provide the opportunity for reimbursement of Premiums for Individual Health Coverage under this Plan.

**D-2 Definitions.** The following defined terms are used in this Appendix D:

(a) "Dependent" means an individual who qualifies as a "dependent" under the terms and conditions of the Individual Health Coverage.

(b) "Premium" means the amount that must be paid on a periodic basis in return for Individual Health Coverage.

(c) "Individual Health Coverage" means: (1) coverage under an individual insurance policy of the type specified in the Plan Information Appendix obtained by a Participant from an insurance carrier, and (2) if specified in the Plan Information Appendix, for Participants who are not eligible for coverage under a group medical plan sponsored by the Employer, coverage under Medicare Parts B and D and a Medicare supplement policy. Notwithstanding the foregoing, the following coverages do not constitute Individual Health Coverage: an insurance policy providing benefits that may not be provided by a cafeteria plan under Section 125 of the Code (e.g., deferred compensation), an individual medical insurance policy; and individual coverage issued through a public insurance exchange.

(d) "Individual Health Premium Account" means the record keeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received.

(e) "Spouse" means an individual who is (1) legally married to a Participant (under applicable state law), and (2) treated as a "spouse" under the applicable section of the Code.

(f) "Tax Dependent" means an individual (other than the Participant and the Participant's Spouse) with respect to whom amounts expended for medical care are excluded from the Participant's gross income under Section 105(b) of the Code, as amended.

**D-3 Benefits.** A Participant is entitled to reimbursement for Premiums the Participant has incurred during the Plan Year, subject to the following:

(a) The Participant shall secure the Individual Health Coverage from the issuer of the coverage (e.g., the insurance carrier). Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the insurance policy governing the Individual Health Coverage. The Individual Health Coverage may include coverage for the Participant's Spouse and Dependents, in addition to the Participant. To the extent a person covered through the Participant is not a Spouse or Tax Dependent of the Participant, the value of the coverage provided to such person(s) shall be included in the Participant's income as the coverage is provided.

(b) A Participant shall not be reimbursed for Premiums incurred during a particular Plan Year except to the extent there are amounts credited to the Participant's Individual Health Premium Account for that Plan Year against which reimbursements may be charged pursuant to Sec. 4.7. Under no circumstances will Premium reimbursements be made with contributions from one Plan Year for coverage actually received in a different Plan Year. In no case shall a payment be made which exceeds the balance in the Participant's Individual Health Premium Account at the time the claim is processed.

(c) Claims under this Appendix shall be made in accordance with this paragraph and rules established by the Plan Administrator.

(1) If elected in the Plan Information Appendix, claims for reimbursement may be made by use of an electronic payment card, subject to the following conditions:

(i) At the beginning of each Plan Year or, if later, upon the Participant's Entry Date, the Participant must pay the initial eligible expense to the insurance carrier and submit a paper claim to the Plan for such expense.

(ii) Upon substantiation by the Plan Administrator (or its designee) of the initial eligible expense, the Plan will make available through the electronic payment card an amount equal to the lesser of: (i) the amount of the approved claim, or (ii) the contributions made by or on behalf of the Participant to the Individual Premium Account for the Plan Year to date.

(iii) The electronic payment card may then be used to pay for subsequently incurred eligible expenses.

(iv) The amount available through the electronic payment card may be increased only as additional eligible expenses are incurred and substantiated via submission of a paper claim, except as provided in paragraph (v) below. In no case will the amount available through the electronic payment card exceed the contributions made by or on behalf of the Participant to the Individual Premium Account for the Plan Year to date minus the amount of expenses previously reimbursed during such Plan Year (whether such reimbursement was made in cash or by crediting the electronic payment card).

(v) Eligible expenses may be automatically substantiated without submission of a paper claim only as provided in this paragraph (v). If (i) an electronic payment card transaction collects information that matches information for a previously approved paper claim with respect to the insurance carrier, and (ii) the amount of the electronic payment card transaction is equal to the previously approved paper claim, then the claim paid via the electronic payment card is substantiated without further review. In such instances, the balance of the electronic payment card may be increased with respect to the automatically substantiated claim once the expense paid through the electronic payment card has been incurred.

(d) Claims for reimbursement of Premiums incurred during the Plan Year must be submitted to the Plan Administrator or its designated agent within ninety (90) days following the end of the Plan Year.

(e) It is intended that the Premiums reimbursed through this portion of the Plan shall be excluded from the Participant's gross income under Sections 106 and 105 of the Code. It is also intended that any benefits received under the Individual Health Coverage shall be excluded from the recipient's gross income to the extent permitted under Section 105(b) of the Code. With respect to coverage that covers a Dependent other than the Participant's Spouse or Tax Dependent, it is intended that (a) value of the coverage be imputed as taxable income to the Participant, and (b) the value of any benefits received as a result of such coverage be excluded from the recipient's gross income to the extent permitted under Section 104(a)(3) of the Code.

(f) Notwithstanding anything in the Plan to the contrary, the Plan and the Employer shall comply with Section 4.13 with respect to the Individual Health Premium Account to the extent required by HIPAA.

## APPENDIX E

## INDIVIDUAL HEALTH PREMIUM PAYMENT FEATURE

**E-1 Purpose.** This Appendix E constitutes a separate written plan for purposes of Sections 105 and 106 of the Code. Its purpose is to provide the opportunity for pre-tax payment of Premiums for Individual Health Coverage under this Plan.

**E-2 Definitions.** The following defined terms are used in this Appendix E:

(a) "Dependent" means an individual who qualifies as a "dependent" under the terms and conditions of the Individual Health Coverage.

(b) "Premium" means the amount that must be paid on a periodic basis in return for Individual Health Coverage.

(c) "Individual Health Coverage" means coverage under an individual insurance policy that is obtained by a Participant from the insurance carrier and that meets the requirements identified in the Plan Information Appendix. Notwithstanding the foregoing, the following coverages do not constitute Individual Health Coverage: an insurance policy providing benefits that may not be provided by a cafeteria plan under Section 125 of the Code (e.g., deferred compensation); an individual medical insurance policy, and individual coverage issued by a public insurance exchange.

(d) "Spouse" means an individual who is (1) legally married to a Participant (under applicable state law), and (2) treated as a "spouse" under the applicable section of the Code.

(e) "Tax Dependent" means an individual (other than the Participant and the Participant's Spouse) with respect to whom amounts expended for medical care are excluded from the Participant's gross income under Section 105(b) of the Code, as amended.

**E-3 Benefits.** A Participant is entitled to pay Premiums incurred during the Plan Year on a pre-tax basis, subject to the following:

(a) The Participant shall secure the Individual Health Coverage from the issuer of the coverage (e.g., the insurance carrier). Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the insurance policy governing the Individual Health Coverage. The Individual Health Coverage may include coverage for the Participant's Spouse and Dependents, in addition to the Participant. To the extent a person covered through the Participant is not a Spouse or Tax Dependent of the Participant, the value of the coverage provided to such person(s) shall be included in the Participant's income as the coverage is provided.

(b) The amount of Premiums paid under the Individual Health Premium Payment Feature during a particular Plan Year shall not exceed the amount of the Participant's salary reduction contributions made pursuant to Sec. 4.1. Under no circumstances will Premium payments be made with contributions from one Plan Year for coverage actually received in a different Plan Year.

(c) The Employer shall pay the Premiums directly to the insurance carrier on an automatic basis in accordance with the rules contained in the Code and the regulations issued thereunder.

(e) It is intended that the Premiums paid by the Participant through this portion of the Plan shall be excluded from the Participant's gross income under Sections 106 and 105 of the Code. It is also intended that any benefits received under the Individual Health Coverage shall be excluded from the recipient's gross income to the extent permitted under Section 105(b) of the Code. With respect to coverage that covers a Dependent other than the Participant's Spouse or Tax Dependent, it is intended that (a) value of the coverage be imputed as taxable income to the Participant, and (b) the value of any benefits received as a result of such coverage be excluded from the recipient's gross income to the extent permitted under Section 104(a)(3) of the Code.

(f) Notwithstanding anything in the Plan to the contrary, the Plan and the Employer shall comply with Section 4.13 with respect to the Individual Health Premium Payment Feature to the extent required by HIPAA.