COUNTY OF CURRITUCK FLEXIBLE BENEFIT PLAN

With Premium Payment, Health FSA and DCAP Components

Effective: July 1, 2020

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ARTICLE I

Introduction

1.1 Amendment and Restatement of Plan
County of Currituck, ("the Employer") hereby amends and restates the provisions of the County of Currituck Flexible Benefit Plan ("the Plan"), as amended, effective as of July 1, 2020. The Plan was originally effective July 1, 2010. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II, Definitions.

This Plan is designed to permit an Eligible Employee to pay for his or her share of Contributions on a pre-tax salary reduction basis under the Premium Benefits, and contribute to the reimbursement benefit(s) on a pre-tax salary reduction basis.

1.2 Legal Status
This Plan is intended to qualify as a "cafeteria plan" under Code section 125 and the regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a "self-insured medical reimbursement plan" under Code section 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code section 105(b). Although reprinted within this document, the Health FSA Component is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The Health FSA Component is also a separate plan for purposes of applicable provisions of COBRA.

The DCAP Component is intended to qualify as a "dependent care assistance program" under Code section 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code section 129(a). Although reprinted within this document, the DCAP Component is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 129.

ARTICLE II

Definitions

"Account(s)" means the Health FSA Accounts described in Article VII and the DCAP Accounts described in Article VIII.

"Appeals Committee" means the Committee appointed by the Employer that acts on behalf of the Plan Administrator with respect to appeals. An external review is available if required by law. The documents assume that no claim under the Cafeteria Plan would constitute a claim for urgent care, so a 24-hour response procedure is not needed.

"Benefits" mean cash, flex credits and the various qualified benefits under Section 125(f) of the Code sponsored by the Employer and made available by the Employer through the Plan, including, but not limited to, premium insurance benefits as described in Section 6.1, medical reimbursement as described in Section 7.1 and dependent care reimbursement as described in Section 8.1.

"Benefit Package Option" means a qualified benefit under Code section 125(f) that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan.

"Change in Status" has the meaning described in Section 10.3.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Compensation" means all the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under sections 125, 132(f)(4), 401(k), 403(b), 408(k) or 457(b) of the Code.

"Contributions" means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits and Section 8.2 for DCAP Benefits.

"DCAP" means dependent care assistance program.

"DCAP Component" means the benefits of this Plan described in Article VIII.

"Dependent" means an individual who qualifies as a dependent of a Participant under Code section 152 (as modified by Code section 105(b)). For purposes of the Premium Payment Benefit(s), "Dependent" does not include any individual who is not a dependent under the underlying insurance contract. A child who is determined to be a Participant's alternate recipient under a qualified medical child support order (QMCSO) under ERISA section 609 shall be considered a Dependent under this Plan, as applicable.

For purposes of the Health FSA expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the end of the calendar year in which the dependent turns age 26.

"Dependent Care Expenses" has the meaning described in Section 8.3.

"Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include (a) any amounts received pursuant to any DCAP established under Code section 129; or (b) any other amounts excluded from earned income under Code section 32(c)(2), such as amounts received under a pension or annuity or pursuant to workers' compensation.

"Effective Date" of this Plan has the meaning described in Section 1.1.

"Election Form/Salary Reduction Agreement" means the actual or deemed paper or electronic form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in the Plan by electing Salary Reductions to pay for any of the Benefits under the Plan. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions. If an interactive voice-response system or web-based program is used for enrollment, the Election Form/Salary Reduction Agreement may be maintained on an electronic database in accordance with applicable laws.

"Electronic Payment Card" means a debit card, stored value card, or credit card that allows a Participant to access funds in a flexible reimbursement arrangement to pay the service provider at the point-of-sale (i.e., the time a service or item is provided).

"Electronic Protected Health Information" has the meaning described in 45 C.F.R. Section 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

"Eligible Employee" means any Employee who is employed by a participating Employer other than:

(a) An Employee covered by a collective bargaining agreement as to which welfare benefits were the subject of good faith bargaining, unless such agreement expressly provides for participation in the Plan;

(b) A non-resident alien with no US source of income;

(c) A "leased employee" within the meaning of Section 414(n);

(d) Employees who are self-employed individuals as defined in section 401(c) of the Internal Revenue Code (including sole proprietors and partners in a partnership);

(e) Employees who own (or are considered to own within the meaning of section 318 of the Internal Revenue Code) more than two percent (2%) of the outstanding stock of an S corporation or stock possessing more than two percent (2%) of the total combined voting power of all stock of such corporation.

In the event an individual who is not characterized or treated by the Participating Employer as a common law employee of a Participating Employer is reclassified as a common law employee of a Participating Employer who meets the definition of an Eligible Employee, the individual shall continue to be excluded from the Plan until the Plan is amended to classify such individual as an Eligible Employee (to the extent such individual otherwise qualifies as an Eligible Employee hereunder). In no event shall such individual be eligible to participate in the Plan prior to the effective date of such Amendment.

The Plan Administrator shall have full and complete discretion to determine eligibility for participation and benefits under this Plan, including, without limitation, the determination of those individuals who are deemed Employees of the Employer (or any controlled group member.) The Plan Administrator's decision shall be final, binding, and conclusive on all parties having or claiming a benefit under this Plan. This Plan is to be construed to exclude, and the Plan Administrator is authorized to exclude, all individuals who are not considered Employees for purposes of the Employer's payroll system.

"Employee" means a person who is currently or hereafter employed by the Employer and any Related Employers that have adopted the Plan. Former Employees are also considered "Employees" of the Employer strictly for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employer" means County of Currituck.

"Employment Commencement Date" means the first regularly-scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"Entry Date" means the date that an Eligible Employee actually becomes a Participant in the Plan. Eligibility requirements are defined in Section 3.1 and the specific Entry Dates for the Plan are listed in Section 3.1.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"General-Purpose Health FSA Option" has the meaning described in Section 7.3(b).

"Grace Period" means the period that begins immediately following the close of a Plan Year and ends on the day specified under the Component plan's Grace Period provision.

"Health Flex Contribution means an employer contribution that: (1) the employee may not opt to receive the amount as a taxable benefit, (2) the employee may use the amount to pay for minimum essential coverage, and (3) the employee may use the amount exclusively to pay for medical care, within the meaning of § 213. A health flex contribution reduces the employee's required contribution and is treated as made ratably for each month of the period to which it relates.

"Health FSA" means health flexible spending arrangement which consists of one (1) option: the General-Purpose Health FSA Option.

"Health FSA Component" means the benefits of this Plan described in Article VII.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HITECH" means the Health Information Technology for Economic and Clinical Health Act.

"Medical Care Expenses" has the meaning defined in Section 7.3.

"Medical Insurance Plan" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies, dental care, vision care, etc. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"National Medical Support Notice" means a standardized medical child support order that is used by state child support enforcement agencies to obtain group health coverage for children.

"Non-Health Flex Contribution" means an employer flex contribution that is available to pay for health care, but may also pay for any non-health care benefits under the § 125 cafeteria plan (such as dependent care or group term life insurance). A non-health flex contribution may be received as cash and does not reduce the employee's required contribution.

"Open Enrollment Period" means with respect to a Plan Year the month preceding the Plan Year, or such other period as may be prescribed by the Plan Administrator.

"Participant" means a person who is an Eligible Employee and who enters the Plan after meeting the eligibility requirements of Section 3.1. Participants include those who elect any benefit(s) offered under the Plan including those covered through COBRA and their respective beneficiaries.

"Participating Employer" means County of Currituck and any Related Employer that adopts the Plan.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

"PHSA" means the federal Public Health Service Act, which contains the provisions of COBRA that govern continuation coverage under government-sponsored Group Health Plans, as well as certain provisions of HIPAA and other federal group health plan mandates that are part of health care reform.

"Plan" means the County of Currituck Flexible Benefit Plan as set forth herein and as amended from time to time.

"Plan Administrator" means County of Currituck or such other person or committee as may be appointed by the Employer to administer the Plan.

"Plan Year" means the 12-month period commencing July 1st and ending on June 30th.

"Premium Payment Benefits" means the benefits of this Plan described in Article VI.

"Protected Health Information" (PHI) shall have the meaning described in 45 C.F.R. Section 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

"Qualified Reservist Distribution" means a distribution of all or a portion of the balance in the employee's account under such arrangement if: (A) such individual is a member of a "reserve component" (as defined in section 101 of title 37, United States Code, which means a member of the Army National Guard; U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard Reserve; Air National Guard of the United States; or the Reserve Corps of the Public Health Service); (B) has been ordered or called to active duty for a period in excess of 179 days or for an indefinite period; (C) the amount of the distribution must be for "all or a portion of the balance in the employee's account"; and (D) the distribution must be made within a certain timeframe. The period for making a qualified reservist distribution begins on the date the reservist is called or ordered to duty and ends on the last day that reimbursements could otherwise be made for the plan year that includes the first day of the distribution period.

"Qualifying Dependent Care Services" has the meaning described in Section 8.3.

"Qualifying Individual" has the meaning described in Section 8.3.

"Related Employer" means any employer affiliated with County of Currituck that, under Code Sections 414(b), (c), or (m), is treated as a single employer with County of Currituck for purposes of Code section 125(g)(4).

"Run-Out Period" means a period after the close of a Plan Year or other period during which Participants in a flexible spending arrangement (FSA) may request reimbursement for expenses incurred during the Period of Coverage.

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable Component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

"Spouse" means an individual who is legally married to a Participant as determined under the laws of the state or sovereign Country where the place of celebration occurred and who is treated as a spouse for federal income tax purposes pursuant to Revenue Ruling 2013-17.

Notwithstanding the above, for purposes of the DCAP Component the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b)

an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"Timely Submitted" means, unless the Plan Administrator has specific and special cause to alter the definition of this phrase, within 30 calendar days of event that has triggered the Change in Status as described in Section 10.2(a).

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III

Eligibility and Participation

3.1 Eligibility to Participate
An individual is eligible to participate in this Plan, including the Premium Payment Benefits, the Health FSA Component, and the DCAP Component, if the individual satisfies all of the following:

(a) is an Eligible Employee; and

(b) is eligible to participate in the Employer's group medical insurance.

Once an Employee has met the Plan's eligibility requirements, the Eligible Employee may commence participation on the same day as the Employer's group medical plan or for any subsequent Plan Year, in accordance with the procedures described in Article IV, Method and Timing of Elections.

3.2 Termination of Participation
A Participant will cease to be a Participant in this Plan upon the earlier of:

- the date on which the Plan terminates;
- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee; or
- the date on which the Employee fails to make a contribution required under the terms of the Plan.

Notwithstanding the above, the Plan Administrator may, in its sole discretion, cause the participation of the Participant and/or their dependents in a benefit plan to terminate if they provide false information or make misrepresentations in connection with a claim for benefits; permit a nonparticipant to use a membership or other identification card for the purpose of wrongfully obtaining benefits; or obtain or attempt to obtain benefits by means of false, misleading, or fraudulent information, acts, or omissions.

Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6. for core health insurance, Section 7.10 for Health FSA Benefits and Section 8.10 for DCAP Benefits.

Except to the extent he or she uses his or her Continuation of Coverage Option (COBRA), an Employee's Account(s) will remain open for the remainder of the Plan Year in which termination occurs but ONLY for reimbursement of expenses incurred prior to Employee's termination date.

Termination of participation in this Plan will automatically revoke the Participant's elections.

The Premium Insurance Benefits will terminate as of the date specified in the Premium Plan.

Reimbursements from the Health FSA Account after termination of participation will be made pursuant to Section 7.10 for Health FSA Benefits.

Reimbursements from the DCAP Account after termination of participation will be made pursuant to Section 8.10 for DCAP Benefits.

3.3 Participation Following Termination of Employment or Loss of Eligibility
If a Participant terminates his or her employment for any reason, including, but not limited to, disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of termination of employment, and is otherwise eligible to participate in the Plan, the Employee will immediately rejoin the Plan and be reinstated with the same elections that the individual had before termination.

If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the Employee will not rejoin the Plan until the first day of the following

Plan Year, regardless of whether or not the Employee should incur an applicable Change in Status. Any unused reimbursement benefit account balance prior to the initial separation of service date will be forfeited.

Notwithstanding the above, an election to participate in the Premium Payment Benefits will be reinstated only to the extent that coverage under the Premium Insurance Benefits is reinstated.

If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including, but not limited to, a reduction of hours, and then becomes an Eligible Employee again, the Employee must re-satisfy (complete the waiting period) Plan eligibility requirements to rejoin the Plan as described in Section 3.1 (or before becoming eligible to participate in the Plan).

3.4 FMLA Leaves of Absence

The Family and Medical Leave Act ('the FMLA') requires employers with 50 or more employees to permit eligible employees to take up to 12 weeks of unpaid, job-protected leave each year because of the birth of a child or the placement of a child for adoption or foster care, to care for an immediate family member who has a serious health condition, or because of the employee's own serious health condition. The FMLA also permits an eligible employee to take up to 12 workweeks of leave during any 12-month period for a "qualifying exigency" arising because the employee's spouse, son, daughter, or parent is on active duty (or has been notified of a call or order to active duty) in the Armed Forces in support of a "contingency operation." In addition, an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member is entitled to take up to 26 workweeks of leave during a 12-month period to care for the service member. These FMLA provisions have been further amended regarding qualifying exigency leave and covered service member leave for employees who are relatives of veterans and members of the Armed Forces.

(a) Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Premium Insurance Benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions. An Employer may require participants to continue all Premium Insurance Benefits and Health FSA Benefits coverage for Participants while they are on paid leave, provided that Participants on non-FMLA paid leave are required to continue coverage. If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax salary reduction basis). In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Premium Insurance Benefits or Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

- Pre-Pay with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);

- Pay-as-you-go with their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations and in a manner approved by the Plan Administrator; or

- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up"

amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Premium Insurance Benefits or Health FSA Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant through a written notice to the Employer.

If a Participant's Premium Insurance Benefits or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Premium Insurance Benefits or Health FSA Benefits as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Premium Insurance Benefits or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining Period of Coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);

- with their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations; or

- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section

10.3 will apply.

ARTICLE IV

Method and Timing of Elections

4.1 Elections When First Eligible
Once an Employee has met the Plan's eligibility requirements, the Employee may enter the plan on the same day as the Employer's group medical plan provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence.

Eligibility for Premium Payment Benefits shall be subject to the additional requirements, if any, as specified by the insurance benefits provider(s). The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified by the insurance benefits provider(s).

4.2 Elections During Open Enrollment Period
During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Eligible Employee. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary salary reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement
If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement (or waiver of pre-tax premiums) within the time period described in Method and Timing of Elections for the first plan year, then the Employee is considered to have elected to participate in the Premium Benefits and will automatically be enrolled in the Premium Benefits, with the employee's salary reduced pretax to pay for a portion of the cost of the coverage, unless the employee affirmatively elects otherwise.

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement for subsequent Plan Years, then the Employee shall continue with same elections as prior year for insured/premium benefits.

4.4 Irrevocability of Elections
Unless an exception applies, as described in Article X, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE V

Benefits Offered and Method of Funding

5.1 Benefits Offered
When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect specific Benefits offered under this Plan:

(a) Premium Payment Benefits, as described in Article VI;

(b) Health FSA Benefits, as described in Article VII; and

(c) DCAP Benefits, as described in Article VIII.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

5.2 Participant Contributions
Participants who elect Benefits under the Plan may pay for the cost of that coverage on a pre-tax salary reduction basis by completing an Election Form/Salary Reduction Agreement.

(a) Salary Reductions. The salary reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (elected under the Plan as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which salary reductions are applied may fluctuate). If a Participant increases his or her election under the benefits elected under the Plan to the extent permitted under Section 10.4, the salary reductions per pay period will be, for the Benefits affected, an amount equal to: (1) the new reimbursement limit elected pursuant to Section 10.4, less the salary reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which salary reductions are applied may fluctuate).

(b) Considered Employer Contributions for Certain Purposes. Salary reductions are applied by the Employer to pay for the Participant's share of the Contributions for the benefits elected under the Plan and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) After-Tax Contributions for Premium Payment Benefits. For those Participants who elect to pay their share of the Contributions for any of the Premium Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

5.3 Funding This Plan
All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

5.4 Maximum Contribution

The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected as Employer and Participant Contributions, as described under each Component.

ARTICLE VI

Premium Payment Benefits

6.1 Benefits
The premium insurance benefits that may be offered under the Premium Payment Benefits for premium-type benefits pursuant to an insurance policy issued by an insurance company, or a contract with a point of service organization are medical, dental, vision, or other qualified benefits under Section 125.

Notwithstanding any other provision in this Plan, the premium insurance benefits are subject to the terms and conditions of the respective insurance policy. No changes can be made with respect to such premium insurance benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable insurance policy. Unless an exception applies, as described in Article X, such election is irrevocable for the duration of the Period of Coverage to which it relates.

6.2 Contributions for Cost of Coverage
The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance provider.

6.3 Events Permitting Exception to Irrevocability Rule
A Participant may make a new election upon the occurrence of certain events, including a Change in Status as described in Section 10.3, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Change in Status means any of the events described below, as well as any other events included under subsequent changes to Code section 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan.

A Participant may change an election under the regulations for the Premium Benefits of this Plan as described below upon the occurrence of the stated events:

(a) Open Enrollment Period
(b) Change in Status:
  (b.1) Change in Employee's Legal Marital Status
  (b.2) Change in the Number of Employee's Dependents
  (b.3) Change in Employment Status of Employee, Spouse or Dependent that Affects Eligibility
  (b.4) Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements
  (b.5) Change in Place of Residence
(c) Cost Changes with Automatic Increase/Decrease in Elective Contributions
(d) Significant Cost Increase or Significant Cost Decrease
(e) Significant Curtailment of Coverage (With or Without Loss of Coverage)
(f) Addition or Significant Improvement of a Benefit Package Option
(g) Change in Coverage Under Another Employer Cafeteria Plan or Qualified Benefits Plan
(h) Loss of Coverage Under Other Group Health Coverage
(i) COBRA Qualifying Events
(j) Certain Judgments, Decrees and Orders (QMCSO)
(k) Medicare and Medicaid Eligibility
(l) FMLA Leaves of Absence

6.4 Insurance Benefits Provided Under the Plan
Insurance benefits will be provided by the insurance provider(s), not this Plan. The types and amounts of insurance benefits, the requirements for participating in each insurance plan, and the other terms and conditions of coverage and benefits of the insurance plan(s) are set forth by the insurance provider. All claims to receive benefits under the insurance plan shall be subject to and governed by the terms and conditions of the insurance plan and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.5 Medical Insurance Benefits: COBRA
Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the medical insurance plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the medical insurance plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for medical insurance benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for medical insurance benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

ARTICLE VII

Health FSA Component

7.1 Health FSA Benefits
An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the Health FSA (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax salary reduction basis. Unless an exception applies (as described in Article X), any such election is irrevocable for the duration of the Period of Coverage to which it relates.

Once an Employee has met the Plan's eligibility requirements, the Eligible Employee may commence participation on the date the eligibility requirements have been met.

7.2 Contributions for Cost of Coverage of Health FSA Benefits
The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant, if applicable.

7.3 Eligible Medical Care Expenses for Health FSA
Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force, or for which Health FSA Benefits are otherwise available as a result of a carryover as provided in Section 7.4.

(a) Incurred. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) Medical Care Expenses. "Medical Care Expenses" will vary depending on which Health FSA coverage option the Participant has elected.

- *General-Purpose Health FSA Option.* For purposes of this Option, "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code section 213(d), provided, however, that this term does not include expenses that are excluded under Appendix A to this Plan, nor any expenses for which the Participant is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan.

  The Plan's provisions regarding permissible pre-tax benefits have been amended to provide that medicines or drugs that are sold lawfully without a prescription need not be prescribed to qualify as Medical Care Expenses reimbursable under the Plan's Health FSA Component, if the expenses for these items are incurred on or after April 1, 2020. In addition, expenses for menstrual care products incurred by you, your Spouse, or your Dependents on or after April 1, 2020, will qualify as Medical Care Expenses. For this purpose, menstrual care product means a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation or other genital-tract secretions.

  If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article. HSA Benefits cannot be elected with a General-Purpose Health FSA.

7.4 Events Permitting Exception to Irrevocability Rule
A Participant may make a new election upon the occurrence of certain events, including a Change in Status as described in Section 10.3, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the

Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

"Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code section 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan.

A Participant may change an election under the regulations for the Health FSA Component of this Plan as described below upon the occurrence of the stated events:

(a) Open Enrollment Period
(b) Change in Status:
  (b.1) Change in Employee's Legal Marital Status
  (b.2) Change in the Number of Employee's Dependents
  (b.3) Change in Employment Status of Employee, Spouse or Dependent that Affects Eligibility
  (b.4) Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements
(c) COBRA Qualifying Events
(d) Certain Judgments, Decrees and Orders (QMCSO)
(e) Medicare and Medicaid Eligibility
(f) FMLA Leaves of Absence

7.5 Maximum Benefits for Health FSA

(a) Maximum Reimbursement Available; Uniform Coverage. The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage and increased by any carryovers as provided below) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.7. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.10. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article have been satisfied.

(b) Maximum Annual Salary Reduction Contributions Limit. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage for the General-Purpose Health FSA shall be $2,750, subject to Section 7.7(c). The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code.

Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) Changes to Dollar Limits. For subsequent Plan Years, the maximum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document provided that the maximum dollar limit shall not exceed the maximum amount permitted under Code section 125(i). If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 7.4, then the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

(d) Carryovers. Notwithstanding any other provision of the Plan to the contrary, unused amounts of

up to $550 remaining in a Participant's Health FSA Account at the end of a Plan Year can be carried over and used to reimburse the Participant for Medical Care Expenses that are incurred during the next Plan Year, subject to the following conditions:

(1) No more than $550 of the Participant's unused Health FSA amount for a Plan Year may be carried over for use in the next Plan Year. Carryover amounts may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum dollar limit. The maximum limit may increase from year-to-year pursuant to Section 125(i) of the Internal Revenue Code.

(2) A Participant who is otherwise eligible for the Health FSA for a Plan Year, but does not make a Health FSA election for that Plan Year may have access to any carryovers from the preceding Plan Year for Medical Care Expenses incurred in the current or preceding Plan Year (as further provided herein). However, an Employee must be a participant in the Health FSA as of the last day of a Plan Year in order to carry over unused amounts to the next Plan Year. Termination of employment and cessation of eligibility will result in a loss of carryover eligibility unless a COBRA election is made.

7.6 Health FSA Benefit Grace Period

No grace period applies to the Health FSA Component of this Plan.

7.7 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage who has elected to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.8.

(a) Crediting of Accounts. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's salary reductions elected to be allocated to such Account.

(b) Debiting of Accounts. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period.

(c) Available Amount Not Based on Credited Amount. As described in Section 7.5, the amount available for reimbursement of Medical Care Expenses is the Participant's annual salary reduction contributions (in addition to nonelective employer contributions to a health FSA, if any), reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage. Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.8 FSA Carryover Rule and Use of Forfeiture

(a) Use-It-or-Lose-It Rule. Except as otherwise provided in Section 7.5(f) (regarding carryovers), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) Use of Forfeitures. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through salary reductions; second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA

Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Run-Out Period in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.9 Reimbursement Claims Procedure for Health FSA

(a) Claims Substantiation. A Participant who has elected to receive Health FSA Benefits for a Period of Coverage, including a Participant who ceases to be eligible to participate either due to termination or loss of eligibility, may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 90th day following the close of the Plan Year in which the Medical Care Expense was incurred setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The request shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request.

If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

(b) Timing. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(c) Claims Denied. For reimbursement claims that are denied, see the appeals procedure in Article XI.

7.10 Reimbursements From Health FSA After Termination of Participation: COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant's salary reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible, provided that the Participant (or the Participant's estate) files a claim within 90 days following the close of the Plan Year in which the Medical Care Expense was incurred.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she

had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA.

Specifically, such individuals will be eligible for COBRA continuation coverage regardless of the Health FSA Account balance at the end of the applicable Period of Coverage (taking into account all claims submitted before the date of the qualifying event).

Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the applicable Period of Coverage; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

7.11 Qualified Reservist Distribution
Under the Health FSA Component, a Participant may receive a distribution of all or a portion of the balance in the employee's account if the distribution qualifies as a "Qualified Reservist Distribution".

"Qualified Reservist Distribution". In order for a distribution to be a "qualified reservist distribution", a number of requirements must be satisfied. First, a "qualified reservist distribution" can be made only to a member of a "reserve component" (as defined in section 101 of title 37 of the United States Code), which means a member of the Army National Guard; U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard Reserve; Air National Guard of the United States; or the Reserve Corps of the Public Health Service. Second, the distributions can be made only to a reservist that, by reason of being a member of a "reserve component", has been ordered or called into active duty (i) in excess of 179 days or more or (ii) for an indefinite period. Third, the amount of the distribution must be for "all or a portion of the balance in the employee's account". Fourth, the distribution must be made within a certain timeframe. The period for making a qualified reservist distribution must be made on or before the last day of the coverage period that includes the date of the reservist's call to active duty and ends on the last day that reimbursements could otherwise be made for the plan year that includes the first day of the distribution period.

A Qualified Reservist will be allowed to cash out the unused benefits and not forfeit them under the "use it or lose it" rule that applies to health FSAs. Specifically, the HEART Act allows for a taxable, penalty-free "qualified reservist distributions" from a health FSA without subjecting other amounts in the cafeteria plan or health FSA to immediate taxation.

7.12 Coordination of Benefits with Other Plans
Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

ARTICLE VIII

DCAP Component

8.1 DCAP Benefits
An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax salary reduction basis. Unless an exception applies (as described in Article X), such election of DCAP Benefits is irrevocable for the duration of the Period of Coverage to which it relates.

Once an Employee has met the Plan's eligibility requirements, the Eligible Employee may commence participation on the date the eligibility requirements have been met.

8.2 Contributions for Cost of Coverage for DCAP Benefits
The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant subject to the dollar limits set forth in Section 8.5(b).

8.3 Eligible Dependent Care Expenses
Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) Incurred. A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) Dependent Care Expenses. "Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code section 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any), and expenses for incidental household services, if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services, provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such expense if it otherwise meets the requirements of this Article.

(c) Qualifying Individual. "Qualifying Individual" means:

- a tax dependent of the Participant as defined in Code section 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code section 152(a)(1);
- a tax dependent of the Participant as defined in Code section 152 who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
- a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced parents, a Qualifying Individual who is a child shall, as provided in Code section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code section 152(e)(3)(A)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

(d) Qualifying Dependent Care Services. "Qualifying Dependent Care Services" means the following: services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the

DCAP Component and during the Period of Coverage; and (2) are performed:

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(e) Exclusions. Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code section 151(c) to a Participant or his or her Spouse;
- a Participant's Spouse; or
- a Participant's child (as defined in Code section 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred.

8.4 Events Permitting Exception to Irrevocability Rule

A Participant may make a new election upon the occurrence of certain events, including a Change in Status as described in Section 10.3, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

"Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code section 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan.

A Participant may change an election under the regulations for the DCAP Component of this Plan as described below upon the occurrence of the stated events:

(a) Open Enrollment Period
(b) Change in Status:
  (b.1) Change in Employee's Legal Marital Status
  (b.2) Change in the Number of Employee's Dependents
  (b.3) Change in Employment Status of Employee, Spouse or Dependent that Affects Eligibility
  (b.4) Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements
(c) Significant Cost Changes: Significant Cost Increase or Significant Cost Decrease
(d) Significant Curtailment of Coverage (With or Without Loss of Coverage)
(e) Addition or Significant Improvement of a Benefit Package Option
(f) Change in Coverage Under Another Employer Cafeteria Plan or Qualified Benefits Plan
(g) FMLA Leaves of Absence

8.5 Maximum Benefits for DCAP

(a) Maximum Reimbursement Available. The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 8.6. No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of

Coverage, less any prior reimbursements). Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied.

(b) Maximum Dollar Limits. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be the maximum limit as indexed under Code section 129(a)(2). Or if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

- the Participant's Earned Income for the calendar year;
- the Earned Income of the Participant's Spouse for the calendar year (Note: A Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense; and (2) is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount indexed under Code section 129(b)(2) per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount indexed under Code section 129(b)(2)); or
- either the maximum statutory limit indexed under Code section 129(a)(2) for the calendar year, as applicable:

  (1) Statutory maximum amount as indexed under Code section 129(a)(2) for the calendar year if one of the following applies:
  - the Participant is married and files a joint federal income tax return;
  - the Participant is married, files a separate federal income tax return, and meets the following conditions: (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or
  - the Participant is single or is the head of the household for federal income tax purposes; or

  (2) Statutory maximum amount indexed under Code section 129(a)(2) for the calendar year if the Participant is married and resides with the Spouse but files a separate federal income tax return.

(c) Changes. For subsequent Plan Years, the maximum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as permitted under Section 8.4, then the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

8.6 Establishment of DCAP Account

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant for each Plan Year or other Period of Coverage who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.8.

(a) Crediting of Accounts. A Participant's DCAP Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's salary reductions elected to be allocated to such Account.

(b) Debiting of Accounts. A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) Available Amount Is Based on Credited Amount. As described in Section 8.5, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

8.7 DCAP Benefits Grace Period

This benefit has a grace period which allows for an additional period of time of 2.5 month(s) following the end of each Plan Year to incur expenses before the "use it or lose it" forfeiture rule applies. Thus, expenses incurred within 2.5 month(s) after the close of the Plan Year can be reimbursed with funds carried over from the prior Plan Year. However, any unused amounts from the prior Plan Year that are not used to reimburse expenses by the end of the grace period remain subject to the "use it or lose it" rule and must be forfeited.

8.8 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing DCAP Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through salary reductions; second, to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

8.8 Reimbursement Claims Procedure for DCAP

(a) Claims Substantiation. A Participant who has elected to receive DCAP Benefits for a Period of Coverage, including a Participant who ceases to be eligible to participate either due to termination or loss of eligibility, may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 90th day following the close of the Plan Year in which the Dependent Care Expense was incurred setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 8.5(b); and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The request shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request.

(b) Timing. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(c) Claims Denied. For reimbursement claims that are denied, see the appeals procedure in Article XI.

(d) Claims Ordering. Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Claims Substantiation procedures will be reimbursed first from any available Prior Plan Year Dependent Care Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year.

If a claim is made for Dependent Care Expenses incurred during a Grace Period, and approved for reimbursement in accordance with the Claims Substantiation procedures, the claim shall be paid in the order in which it is adjudicated and shall be irrevocable, except that if the Dependent Care is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Dependent Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year Dependent Care Amounts if the card is unavailable for such reimbursement.

8.9 Reimbursements From DCAP After Termination of Participation
When a Participant ceases to be a Participant under Section 3.2, the Participant's salary reductions and election to participate will terminate.

The Participant will be able to receive reimbursements for Dependent Care Expenses incurred during the Period of Coverage following termination through the end of the Plan Year.

8.10 Report to DCAP Participants
On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the salary reductions for the year for the DCAP Component, as the Plan Administrator deems appropriate.

ARTICLE IX

HIPAA Provisions

9.1 Provision of Protected Health Information to Employer
Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA and Premium Benefits. When this health information is provided from the Health FSA and Premium Benefits to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article:

> Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased. The Employer shall have access to PHI from the Health FSA and Premium Benefits only as permitted under this Article or as otherwise required or permitted by HIPAA.
>
> The Health Information Technology for Economic and Clinical Health Act passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules. HITECH defines an EHR as "electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff."

9.2 Permitted Disclosure of Enrollment/Disenrollment Information
The Health FSA and Premium Benefits may disclose to the Employer information on whether the individual is participating in the Plan.

9.3 Permitted Uses and Disclosure of Summary Health Information
The Health FSA and Premium Benefits may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health FSA and Premium Benefits.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

9.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes
Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 9.5 and obtaining written certification pursuant to Section 9.7, the Health FSA and Premium Benefits may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Health FSA and Premium Benefits, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f).

9.5 Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA and Premium Benefits, the Employer shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA and Premium Benefits agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- 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;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health FSA and Premium Benefits available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA and Premium Benefits with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Health FSA and Premium Benefits that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between the Health FSA and Premium Benefits and the Employer (i.e., the "firewall"), required in 45 CFR Section 504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Health FSA and Premium Benefits, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA and Premium Benefits any security incident of which it becomes aware.

9.6 Adequate Separation Between Plan and Employer

The Employer shall allow the following persons access to PHI: the Human Resource Manager, Human Resource and payroll staff performing Health FSA functions, the Benefits Manager, the Plan Administrator, and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Health FSA and Premium Benefits (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Health FSA and Premium Benefits. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

9.7 Certification of Plan Sponsor

The Health FSA and Premium Benefits shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR

Section 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 9.5.

ARTICLE X

Irrevocability of Elections; Exceptions

10.1 Irrevocability of Elections
Except as described in this Article, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan;
- salary reduction amounts; or
- election of particular Benefit Package Options (including the various Health FSA Options).

10.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) Timeframe for Making New Election. A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 4.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 10.3, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period. Notwithstanding the foregoing, a Change in Status (e.g., a divorce) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) Effective Date of New Election. Elections made pursuant to this Section shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. All election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

(c) Effect of New Election Upon Amount of Benefits. For the effect of a changed election upon the maximum and minimum benefits under the Health FSA, see Section 7.5 and DCAP Component, see Section 8.5.

10.3 Change in Status Defined
A Participant may make a new election upon the occurrence of certain events as described below, including a Change in Status, for the applicable Component, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

"Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code section 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) Open Enrollment Period. A Participant may change an election during the Open Enrollment Period in accordance with Section 4.2.

(b) Termination of Employment. A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.2 and 3.3, as applicable.

(c) Legal Marital Status. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment.

(d) Number of Dependents. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption.

(e) Employment Status. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan.

(f) Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, or any similar circumstance.

(g) Change in Residence. A change in the place of residence of the Participant or his or her Spouse or Dependents that causes the gain or loss of eligibility for coverage option.

(h) Leaves of Absence. A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(h.1) Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

(h.2) Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(i) HIPAA Special Enrollment Rights. If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(i.1) a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

(i.2) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

An election change on account of a HIPAA special enrollment attributable to an employee or dependent becoming eligible for a state premium assistance subsidy under the plan from Medicaid or SCHIP may, subject to the provisions of the underlying group health plan be effective retroactively (up to 60 days).

(j) Certain Judgments, Decrees and Orders. If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(k) Medicare and Medicaid. If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid.

(l) Change in Cost. For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(l.1) Increase or Decrease for Insignificant Cost Changes. Participants are required to increase their elective contributions (by increasing salary reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage

of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(l.2) Significant Cost Increases. If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing salary reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage.

(l.3) Significant Cost Decreases. If the Plan Administrator determines that the cost of any Benefit Package Option significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option (such as an HMO, but not the Health FSA) other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); and (b) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option.

(l.4) Limitation on Change in Cost Provisions for DCAP Benefits. The "Change in Cost" provisions apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code section 152(d)(2)(A) through (G), incorporating the rules of Code section 152(f)(1) and 152(f)(4).

(m) Change in Coverage. For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(n) Significant Curtailment. If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer.

(n.1) Significant Curtailment Without Loss of Coverage. If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(n.2) Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that a Participant's Benefit Package Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing

similar coverage is offered by the Employer.

(n.3) Definition of Loss of Coverage. For purposes of this Section, a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(o) Addition or Significant Improvement of a Benefit Package Option. If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option.

(p) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code §7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(q) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the Plan Year under the other cafeteria plan or qualified benefits plan. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

10.4 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their salary reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator

will reduce the salary reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest salary reduction amount and continuing with the Participant in the class who had elected the next-highest salary reduction amount, and so forth, until the defect is corrected.

ARTICLE XI

Appeals Procedure

11.1 Procedure If Benefits Are Denied Under This Plan
If a claim for reimbursement or benefit under this Plan is wholly or partially denied, such claim shall be administered in accordance with the procedure set forth below and in the summary plan description of this Plan. The Appeals Committee, separate and distinct from the individual(s) that adjudicate the claims, shall act on behalf of the Plan Administrator with respect to appeals. An external review process shall be provided as legally required and as further set forth below.

Claims Under the Health FSA or DCAP Components
If (a) a claim for reimbursement under the Health FSA or DCAP Components of the Cafeteria Plan is wholly or partially denied, or (b) Participant is denied a benefit under the Plan due to an issue germane to said coverage under the Plan, then the procedure described below will apply.

If a claim is denied in whole or in part, Participant will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received the claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow the Participant 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on the claim until the specified information is provided.)

Notification of a denied claim will include:

- a statement of the specific reason(s) for the denial;
- reference(s) to the specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for Participant to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if Participant wishes to appeal the Plan Administrator's decision, including their right to submit written comments and have them considered, their right to review (upon request and at no charge) relevant documents and other information, and their right to file suit (where applicable) with respect to any adverse determination after appeal of their claim.

Appeals
If a claim is denied in whole or in part, then the Participant (or authorized representative) may request review upon written application to the Appeals Committee. The appeal must be made in writing within 180 days after Participant's receipt of the notice that the claim was denied. If Participant does not appeal on time, Participant will lose the right to appeal the denial and the right to file suit in court. Participant's written appeal should state the reasons that they feel their claim should not have been denied. It should include any additional facts and/or documents that they feel support their claim. Participant will have the opportunity to ask additional questions and make written comments, and Participant may review (upon request and at no charge) documents and other information relevant to their appeal. If the denial involves a Disability benefit claim, a denial includes a cancellation or discontinuance of coverage that has retroactive effect (unless it is due to the Participant's failure to pay required premiums).

Participant will not be allowed to take legal action against the Plan, the Employer, the Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless they exhaust the internal appeal rights. A Participant does not have to pursue external review in order to preserve the right to file a lawsuit; however, a Participant may be unable to take further legal action if they pursue an external appeal because the external appeal process results in a binding determination.

Decision on Review of Internal Appeal
Participant's internal appeal will be reviewed and decided by the Appeals Committee within a reasonable time not later than 60 days after the Appeals Committee receives Participant's request for review. The Appeals Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with their internal appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with the internal appeal will be provided. If the decision on review affirms the initial denial of the claim, Participant will be furnished with a notice of adverse benefit determination on review setting forth:

- a statement of the specific reason(s) for the decision on review;
- reference(s) to the specific Plan provision(s) on which the decision is based;
- a statement of Participant's right to review (upon request and at no charge) relevant documents and other information; and
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to Participant upon request or a statement that such a rule, guideline, protocol, or other similar criterion does not exist; and
- a statement of Participant's right to bring an external appeal or a civil action including the calendar date that the contractual limitations period expires for the claim (where applicable).

If the denial involves a Disability benefit claim or a group health plan claim, the following additional information will be included on the notice of adverse benefit determination:

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the specific medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination presented to the Plan made by the Social Security Administration; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Participant may have the right to an external review of the Administrator's denial of the internal appeal unless the Benefit denial was based on the Participant's (or their Spouse's or Dependent's) failure to meet the Plan's eligibility requirements.

Requirements for an External Appeal
Participant may request an external appeal by completing the form provided by the Administrator which must include the following information:

- Participant's name, address, daytime telephone number and email address; and
- A brief description of why the Participant disagrees with the decision, along with any additional information, such as a physician's letter, bills, medical records, or other documents to support their claim.

Deadline for filing an External Appeal
Participant's external appeal must be filed with the external reviewer within four (4) months of the date the Participant was served with the Administrator's response to their internal appeal request. If Participant does

not file an external appeal within this 4-month period, the Participant shall lose the right to appeal. For example, if Participant received the internal appeal decision on January 3, 2012, they must appeal the decision by May 3, 2012 (or, if that is not a business day, the next business day thereafter).

The plan must complete a preliminary review within five (5) business days upon receipt of the external review request to determine if the claimant was covered under the plan, the claimant provided all of the necessary information to process the external review and that the claimant has exhausted the internal appeals process. The plan must provide the claimant written notice of its preliminary review determination within one (1) business day after completing its review. If the request is complete, but not eligible for external review, the notice must state the reasons for the ineligibility and provide EBSA contact information. If the request is incomplete, the notice must describe the information or materials needed to complete the request. The plan must permit the claimant to "perfect" (i.e., complete) the external review request within the four-month filing period or, if later, 48 hours after receipt of the notice.

Decision on Review of External Appeal
The plan must assign an accredited Independent Review Organization (IRO) to perform the external review. The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

Duty of Beneficiary/Third Party Recoveries
Any Beneficiary under the Plan that receives a payment, whether by lawsuit, settlement, or otherwise, from third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party must reimburse the Plan to the extent the Beneficiary has received payments from the Plan for such sickness or injury. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

The Plan further requires covered Beneficiaries promptly advise the Plan Administrator of third-party claims and to execute any assignments, liens, or other documents the Plan Administrator requests. The Plan may withhold Benefits until such documents are received.

Subrogation/Acts of Third Parties
The Plan Administrator, on behalf of the Plan, has the right to recover any payments made to Beneficiaries, whether by lawsuit, settlement, or otherwise, by third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

11.2 Claims Procedures for Medical Insurance Benefits
Claims and reimbursement for Medical Insurance Benefits shall be administered in accordance with the claims procedures for the Medical Insurance Benefits, as set forth by the provider.

ARTICLE XII

Recordkeeping and Administration

12.1 Plan Administrator
The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

12.2 Powers of the Plan Administrator
The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section the Appeals Committee shall exercise such exclusive power with respect to an appeal of a claim as outlined in the Appeals Procedure Section);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to provide the Employer with such tax or other information it may require in connection with the Plan;

(g) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(h) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(i) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(j) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(k) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(l) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

(m) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year regarding the administration of the Plan, and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might ensure the efficient administration of the Plan.

However, nothing in this Section is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure, or Benefit Provider. Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he or she sees fit to assure that the Plan complies with the nondiscrimination requirements of Section 125 of the Code.

12.3 Reliance on Participant, Tables, etc.
The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

12.4 Provision for Third-Party Plan Service Providers
The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

12.5 Fiduciary Liability
To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

12.6 Compensation of Plan Administrator
Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

12.8 Insurance Contracts
The Employer shall have the right to: (a) enter into a contract with one or more insurance companies for the purpose of providing any benefits under the Plan; and (b) replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

12.9 Inability to Locate Payee
If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

12.10 Effect of Mistake
In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible

under Code section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XIII

General Provisions

13.1 Plan Expenses
All reasonable expenses incurred in administering the Plan are currently paid by both, the Employer and the participants' account balances. The Employer has the discretion to decide upon an appropriate expense amount to offset experience gains.

13.2 No Contract of Employment
Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

13.3 Amendment and Termination
This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

13.4 Governing Law
This Plan shall be construed, administered, and enforced according to the laws of the State of North Carolina, to the extent not superseded by the Code.

13.5 No Guarantee of Tax Consequences
Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

13.6 Indemnification of Employer
If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

13.7 Non-Assignability of Rights
The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

13.8 Headings
The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

13.9 Plan Provisions Controlling
In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

13.10 Severability
Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

*** * ***

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the County of Currituck Flexible Benefit Plan, County of Currituck has caused this Plan to be executed in its name and on its behalf, on this 1st day of July, 2020.

Employer:
County of Currituck

_____
Authorized Signature

Appendix A

Exclusions-Medical Expenses That Are Not Reimbursable From the Health FSA
The County of Currituck Flexible Benefit Plan document contains the general rules governing what expenses are reimbursable. This Appendix A, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA-that is, expenses that are not reimbursable, even if they meet the definition of "medical care" under Code section 213(d) and may otherwise be reimbursable under the regulations governing Health FSAs.

Exclusions: The following expenses are not reimbursable from the Health FSA, even if they meet the definition of "medical care" under Code section 213(d) and may otherwise be reimbursable under regulations governing Health FSAs: (subject to change per IRS)

- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care.
- The cost of sending a child with behavioral problems to a school where the course of study and the disciplinary methods have a beneficial effect on the child's attitude if the availability of medical care in the school isn't a principal reason for sending the student there.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code section 213(d).
- Any item that is not reimbursable under Code section 213(d) due to the rules in Prop. Treas. Reg. Section 1.125-2, Q-7(b)(4) or other applicable regulations.