Flexible Benefits (125) Plan

PLAN DOCUMENT

for

SAMPLE

MidAmerica
Administrative & Retirement Solutions, Inc.

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FLEXIBLE BENEFITS PLAN

Adopting MidAmerica Administrative & Retirement Solutions, Inc. Basic Plan Document

PREAMBLE

The Employer hereby establishes a Flexible Benefits Plan (the "Plan") for its Employees for purposes of providing eligible Employees with the opportunity to choose among the fringe benefits available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Internal Revenue Code Section 125.

The Health Care Reimbursement Account ("HCRA") is intended to qualify as a Code Section 105 medical expense reimbursement plan, and the Dependent Care Reimbursement Account ("DCRA") is intended to qualify as a Code Section 129 dependent care assistance plan. Although printed within this one document, the HCRA and DCRA Plans are separate written plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Sections 105 and 129 of the Code, as well as all applicable provisions of ERISA if the Employer is other than a governmental employer.

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ARTICLE I

Definitions

1.01 **Affiliated Employer** means any entity which, within the context of Code Section 414(b), (c), or (m), or other applicable regulations and IRS Notices, Revenue Procedures and the like will be considered with the Employer as a single employer for purposes of Code Section 125.

1.02 **After-tax Contribution(s)** means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement, after any applicable state and federal taxes have been deducted, for purposes of purchasing one or more of the Benefit Package Options available under the Plan.

1.03 **Anniversary Date** means the first day of any Plan Year.

1.04 **Benefit Credits** means any amount which the Employer may provide to Participants to apply towards the cost of one or more of the Benefit Package Option(s) elected by the Participant. The amount of Benefit Credits allocated to eligible Participants may be adjusted upward or downward on an annual basis before the beginning of each Plan Year in the contributing Employer's sole discretion. The amount of Benefit Credits, if any, will be calculated each Plan Year in a uniform and non-discriminatory manner based upon the Participant's dependent status, commencement date of the Participant's employment during the Plan Year and/or such other factors as the Employer shall determine. The Benefit Credits, if any, will be set forth in the Adoption Agreement (and/or the enrollment materials). Benefit Credits will not be disbursed to a Participant in the form of additional Compensation if the total cost of the Benefit Package Option(s) elected by the Participant is less than the Benefit Credits allocable thereto or if the Employee declines coverage under the Benefit Package Option(s).

1.05 **Benefit Package Option(s)** means those Qualified Benefits available to a Participant as selected in the Adoption Agreement, as the same may be amended and/or replaced from time to time.

1.06 **Board of Directors** means the Board of Directors of a non-governmental Employer. The Board of Directors, upon adoption of this Plan, appoints the Committee to act on the Employer's behalf in all matters regarding the Plan.

1.07 **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 under Code Section 125 which the Plan Administrator (in its sole discretion) chooses to incorporate in the Plan to be applied on a uniform and consistent basis:

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

(b) **Change in Number of Tax Dependents (as defined in Section 1.11)**. A change in the Participant's number of tax Dependents, including the birth of a child, the adoption or placement for adoption of a Dependent, or the death of a Dependent;

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(c) **Change in Employment Status**. Any of the following events that change the employment status of the Participant, the Participant's Spouse or the Participant's Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the employer of the Participant, the Participant's Spouse or the Participant's Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the Plan, then that change constitutes a change in employment hereunder;

(d) **Dependent Eligibility Requirements**. An event that causes a Participant's Dependent to satisfy (or cease to satisfy) the eligibility requirements for a particular benefit, such as attaining a specified age, getting married or ceasing to be a Student;

(e) **Change in Residence**. A change in the place of residence of the Participant, the Participant's Spouse or the Participant's Dependent; or

(f) **Adoption Assistance**. A commencement or termination of adoption proceedings under an adoption assistance program.

Note: See Section 3.05 for requirements that must be met to permit certain mid-year election changes on account of a Change in Status. In all events, a Participant's revocation of a Plan election during a Plan Year of coverage and new election for the remaining portion of the Plan Year must be consistent with the Change in Status.

1.08 **Code** means the Internal Revenue Code of 1986, as amended.

1.09 **Committee** or **Plan Administrator** means the person(s) appointed by the Employer with authority and responsibility to manage and direct the operation and administration of the Plan.

1.10 **Compensation** means the cash wages or salary paid to an Employee by the Employer before any reduction under Section 125 or Section 401(k) of the Code.

1.11 **Dependent** means any individual who is a tax dependent of the Participant as defined in Code Section 152(a); provided, however, that in the case of a divorced Employee (a) Dependent shall be defined as in Code Section 21(e)(5) (i.e. dependent of the parent with custody) for purposes of the Dependent Care Reimbursement Plan; and (b) for purposes of accident or health coverage, a child shall be considered a Dependent of both parents; provided, however, that for purposes of accident or health coverage, including the Health Care Reimbursement Account, Dependent means (1) any individual who is a tax dependent of the Participant as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (2) any child (as defined in Code Section 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age twenty-seven (27).

1.12 **Dependent Care Reimbursement** shall have the meaning assigned to it by Section 5.01(b) of the Plan.

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1.13 **Earned Income** means all income derived from wages, salaries, tips, self-employment, and other Employee Compensation (such as disability or wage continuation benefits), but does not include (a) any amounts received pursuant to any dependent care assistance program under Code Section 129, (b) any amount received as a pension or annuity, or (c) workers' compensation.

1.14 **Effective Date** means the date specified in the Adoption Agreement executed by the Employer.

1.15 **Eligible Employment-Related Expenses** means those Qualifying Employment-Related Expenses (as defined in Section 1.30) paid or incurred incident to maintaining or seeking gainful employment after the date of the Employee's participation in the Dependent Care Reimbursement Account and during the Plan Year, other than amounts paid to:

(a) an individual with respect to whom a Dependent deduction is allowable under Code Section 151(a) to the Participant or his or her Spouse;

(b) the Participant's Spouse; or

(c) a child of the Participant who is under 19 years of age at the end of the year in which the expenses were incurred.

1.16 **Eligible Medical Expenses** means those expenses incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the HCRA and during the Plan Year if the expense is for "medical care" as defined in Code Section 213(d), including, but not limited to, prescription and over-the-counter, but shall not include: (a) expenses for qualified long-term care services (as defined in Code Section 7702B(c)), (b) an expense incurred for the payment of premiums under a health insurance plan and (c) an expense that has been or will be reimbursed by any other source. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

Effective January 1, 2011, **Eligible Medical Expenses** is amended to mean those expenses incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the HCRA and during the Plan Year if the expense is for "medical care" as defined in Code Section 213(d), including, but not limited to, prescription drugs and prescribed over-the-counter medicines or, but shall not include: (a) expenses for qualified long-term care services (as defined in Code Section 7702B(c)), (b) an expense incurred for the payment of premiums under a health insurance plan, (c) an expense that has been or will be reimbursed by any other source, and (d) an expense for a medicine or drug incurred on or after January 1, 2011 unless such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

1.17 **Employee** means an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any leased employee (including, but not limited to, those individuals defined in Code Section 414(n)), or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such persons are on the

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Employer's W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement, except as may otherwise be provided for in the collective bargaining agreement.

1.18 **Employer** means the Employer adopting this Plan and any Affiliated Employer authorized by the Employer to adopt the Plan and who adopts the Plan, provided, however, that when the Plan provides that "the Employer" has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third-party insurer, or amendment or termination of the Plan), the term shall not include Affiliated Employers adopting the Plan. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended by the Employer until they withdraw in writing from participation herein. Affiliated Employers who have adopted the Plan will be listed in the Adoption Agreement. Affiliated Employers shall adopt the Plan by separate resolution and shall sign such documents as the Employer shall require.

1.19 **ERISA** shall mean the Employee Retirement Income Security Act of 1974, as amended. References herein to ERISA shall not apply to governmental Employers.

1.20 **Health Care Reimbursement** shall have the meaning assigned to it by Section 5.01(a) of the Plan.

1.21 **Highly Compensated Individual** means an individual defined under Code Section 105(h)(5), 125(e), or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.22 **Key Employee** means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.

1.23 **Nonelective Contribution(s)** means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Dependents, if applicable, under one or more of the Benefit Package Option(s) offered under the Plan. The manner in which such amounts are applied towards the cost of the Benefit Package Option(s) shall be in the sole discretion of the Employer. The amount of Nonelective Contribution for each Participant may be adjusted upward or downward in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall determine. In no event will any Nonelective Contribution be disbursed to a Participant in the form of additional, taxable Compensation if the Employee declines coverage under one or more of the Benefit Package Option(s) offered under the Plan. Any unused Non-Elective Contributions shall be returned to the Employer.

1.24 **Participant** means an Employee who becomes a Participant pursuant to Article II.

1.25 **Plan** means this Flexible Benefits (125) Plan.

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1.26 **Plan Administrator** or **Committee** means the person(s) appointed by the Employer with authority and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

1.27 **Plan Year** shall be the 12-month period indicated in the Adoption Agreement, provided, however, that a period of less than 12 months may be a Plan Year for the Initial Plan Year, the final Plan Year, and a transition period to a different Plan Year.

1.28 **Pre-tax Contribution(s)** means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement, before any applicable state and federal taxes have been deducted, for purposes of purchasing one or more of the Benefit Package Options available under the Plan. This amount shall not exceed the premiums attributable to the most costly Benefit Package Option afforded hereunder, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

1.29 **Qualified Benefit** means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code (other than Sections 106(b), 117, 124, 127, or 132) and any other benefit permitted by the Income Tax Regulations (i.e., any group-term life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Section 79). Long-term care insurance is not a "Qualified Benefit."

1.30 **Qualifying Employment-Related Expenses** means those expenses that would be considered to be employment-related expenses under Code Section 21(b)(2) (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services.

1.31 **Qualifying Individual** means:

(a) a Dependent of the Participant who is under the age of 13;

(b) a Dependent of a Participant who is mentally or physically incapable of caring for himself or herself and who has the same principal place of residence as the Participant for more than one half of the Plan Year; or

(c) the Spouse of a Participant who is mentally or physically incapable of caring for himself or herself and who has the same principal place of residence as the Participant for more than one half of the Plan Year.

1.32 **Qualifying Services** means services relating to the care of a Qualifying Individual that enable the Participant or his or her Spouse to remain gainfully employed (or to actively seek gainful employment) which are performed:

(a) in the Participant's home; or

(b) outside the Participant's home for (i) the care of a Dependent of the Participant who is under age 13, or (ii) the care of any other Qualifying Individual who resides at least 8 hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care

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for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

1.33 **Reimbursement Account or Accounts** shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for reimbursement of eligible expenses as defined herein. No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).

1.34 **Salary Reduction Agreement** means the actual or deemed agreement pursuant to which an eligible Employee or Participant enrolls in the specific component Benefit Package Options with Pre-tax Contributions or After-tax Contributions in accordance with the provisions hereof. If the Employer utilizes an interactive voice response (IVR) system or web-based program for enrollment, the Salary Reduction Agreement may be maintained on an electronic database.

1.35 **Spouse** means an individual who is legally married to a Participant (and who is treated as a spouse under the Code), but for purposes of the Dependent Care Reimbursement Plan provisions, shall not include an individual legally separated from the Participant under a divorce or separate maintenance decree, nor shall it include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual.

1.36 **Student** means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented.

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ARTICLE II

Eligibility and Participation

2.01 **Eligibility to Participate**. Each Employee who is eligible for coverage or participation under any of the Benefit Package Options, as specified in the Adoption Agreement, shall be eligible to become a Participant in this Plan as of the time specified in the Adoption Agreement. The eligibility for Benefit Package Option(s) offered under the Plan shall be subject to any requirements specified in the applicable Benefit Package Option. The provisions of this Article are not intended to override any eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Package Options.

2.02 **Eligibility to Participate in Reimbursement Accounts**. Each Employee shall become eligible to Participate in the Reimbursement Accounts upon satisfaction of the applicable eligibility requirement(s) set forth in the Adoption Agreement. Employees covered under a collective bargaining agreement will only be eligible to participate in Reimbursement Accounts if participation shall be provided for in the collective bargaining agreement.

2.03 **Termination of Participation**. Participation shall terminate on the earliest of: (a) the date an Employee ceases to be an Employee (except as otherwise provided in Section 5.05 for COBRA coverage); (b) when an Employee ceases to meet the eligibility requirements for the Benefit Package Option; (c) the date this Plan is amended to exclude the Employee or is terminated; or (d) the effective date of the Employee's election not to participate pursuant to applicable provisions of Article III. Subject to any specific limitations for any particular benefit which the Participant has elected: (a) participation shall be continued during a leave of absence for which the Participant continues to receive a salary from his or her employer and (b) participation shall be suspended during an unpaid leave of absence.

2.04 **Qualifying Leave Under Family Leave Act**. Notwithstanding any provision to the contrary herein, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA"), to the extent required by the FMLA, the Employer will continue to maintain the Participant's medical coverage on the same terms and conditions as though he or she were still an active Employee (i.e., the Employer will continue to pay its share of the premium to the extent the Employee opts to continue his or her coverage). If the Employee opts to continue his or her coverage, the Employee may pay his or her share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent he or she receives Compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his or her share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of his or her pre-leave Compensation by making a special election to that effect prior to the date such Compensation would normally be made available to him or her (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Employer (e.g., the Employer may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to re-enter the Plan on the same basis the Employee was participating in the Plan prior to his or her leave, or as otherwise required by the FMLA.

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ARTICLE III

Benefit Package Options and Election Procedure

3.01 **Benefit Package Options**. A Participant may elect under this Plan to receive his or her total Compensation for any Plan Year in cash or designate that a specified portion of his or her Compensation be applied by the Employer toward any or a combination of the following benefit options:

(a) **Option A:** Group insurance contracts and prepaid health plan contracts for Employer-sponsored health insurance;

(b) **Option B:** Benefits available under the Health Care Reimbursement Account; and

(c) **Option C:** Benefits available under the Dependent Care Reimbursement Account.

3.02 **Description of Benefits Other than Cash**. While the election to receive any of the optional benefits described herein may be made under this Plan, the benefits will be provided not by this Plan, but by the applicable health insurance policy, the Health Care Reimbursement Account or the Dependent Care Reimbursement Account, respectively. The types and amounts of benefits available under each option elected in the Adoption Agreement, the requirements for participating in such option, and the other terms and conditions of coverage and benefits under such option are as set forth and as in effect at any time in any health insurance policies or contracts that constitute (or are incorporated by reference in) any health plan, the Health Care Reimbursement Account and the Dependent Care Reimbursement Account. The benefit descriptions in such Plans and contracts, as in effect at any time, are hereby incorporated by reference into this Plan.

3.03 **Election of Benefit Options in Lieu of Cash**. A Participant may elect under this Plan to receive any or all of the benefit options elected in the Adoption Agreement in accordance with the procedure described in Section 3.04 hereof.

(a) If Option A is made available by an Employer and a Participant elects Option A, the Participant's cash Compensation will first be reduced, and an amount equal to such reduction will be applied by the Employer to pay the Participant's share of the insurance premiums.

(b) If Option B is made available by an Employer and a Participant elects the Health Care Reimbursement Account, the Participant's cash Compensation will be reduced, and an amount equal to the reduction will be credited by the Employer to a spending account as described in Section 4.04 hereof.

(c) If Option C is made available by an Employer and a Participant elects the Dependent Care Reimbursement Account, the Participant's cash Compensation will be reduced, and an amount equal to the reduction will be credited by the Employer to a spending account as described in Section 4.05 hereof.

3.04 **Election and Salary Reduction Procedures**.

(a) **Election Period**. Except as provided in Section 3.05, the benefit options may be elected, modified or revoked by a Participant only during an Election Period. The

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Election Period for the initial Plan Year shall begin approximately 30 days prior to the commencement of the initial Plan Year, and each subsequent Election Period shall begin approximately 60 days prior to the commencement of the Plan Year. Election Periods shall, however, be at the sole discretion of the Employer and nothing herein shall invalidate the duration of an Election Period selected by an Employer. Each Election Period shall remain open until such date as the Plan Administrator shall determine, which date must be no later than the day before the next Plan Year.

Employees who are hired or become eligible after the Effective Date shall have an Election Period that shall commence prior to the Participant becoming eligible and shall end on such dates as the Plan Administrator shall establish. In no event shall such Election Period end after the coverage has begun.

(b) **Election Procedures**. At the beginning of each Election Period, the Plan Administrator shall provide one or more written election forms and Salary Reduction Agreements to each eligible Employee. Each eligible Employee shall make his or her elections, revocations or modifications on the necessary forms and shall agree to any reduction in Compensation by executing a Salary Reduction Agreement.

(c) **Modification of Election; Failure to Elect**. Except as provided herein for acceptable benefit changes, each election shall remain in effect for the applicable Plan Year for which such election applies. A Participant may modify or revoke an election to participate or elect to participate in any option during the Election Period for the next Plan Year. Each election is independent of the others.

A Participant in the prior Plan Year who fails to return a completed Salary Reduction Agreement to the Plan Administrator on or before the end of an Election Period shall be deemed to have completed the same election for Option A as in the prior Plan Year, and his or her Compensation shall be reduced in the same amount (or under the same guidelines) as in the prior Plan Year.

A Participant in the prior Plan Year who fails to return a completed Salary Reduction Agreement to the Plan Administrator on or before the end of an Election Period shall be deemed to have elected to receive his or her Compensation in cash in lieu of any amounts previously deducted for Options B and C, and he or she shall not be eligible to participate under this Plan in Options B and/or C (as permitted by the Employer) until the next Plan Year, unless the eligible Employee demonstrates a change in family status as defined in Section 3.05 or other event permitting an election change. The Participant's election for Option A in the prior Plan Year shall be continued for the next Plan Year.

An eligible Employee who has elected not to participate during the Plan Year is not eligible to enroll or re-enroll until the Election Period for the next succeeding Plan Year, unless the eligible Employee can demonstrate a change in status as defined in Section 3.05 or other event permitting an election change.

3.05 **Change of Benefit Election**. A Participant shall not make any changes to the Pre-tax Contribution amount or to the Participant's elected allocation of Benefit Credits, if any, except for election changes permitted under this section, and for changes made during the annual Election Period, changes caused by termination of employment (Section 3.06) and changes pursuant to the Family and Medical Leave Act (Section 2.04).

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Except as provided in Section 3.05(b) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all permissible 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 first pay period coinciding with or immediately 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 the coverage in the applicable component plan commences later.

(a) **Change in Status**. A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status, 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. A Change in Status that affects eligibility for coverage 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. The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status.

Assuming 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:

(1) **Loss of Dependent Eligibility**. 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 ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent who 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, the Participant's Spouse or the Participant's Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's Plan, 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).

(2) **Gain of Coverage Eligibility Under Another Employer's Plan**. For a Change in Status in which a Participant, a Participant's Spouse, or a Participant's Dependent gains eligibility for coverage under another employer's cafeteria plan (or another employer's qualified benefit plan) 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 other employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under

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the other employer's plan, unless the Employer has reason to believe that the Participant's certification is incorrect.

(3) **Special Consistency Rule for DCRA**. With respect to the DCRA (when offered under the Plan), a Participant may change or terminate his or her election upon a Change in Status if (i) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage or (ii) the election change is on account of and corresponds with a Change in Status that affects eligibility of dependent care expenses for the tax exclusion available under Code Section 129.

(4) **Special Consistency Rule for Group Term Life Insurance, Disability and Dismemberment Coverage**. For any Change in Status, a Participant may elect either to increase or to decrease group-term life insurance, disability coverage, or accidental death and dismemberment coverage which may be offered under the Plan.

(b) **HIPAA Special Enrollment Rights**. If a Participant, a Participant's Spouse or a Participant's Dependent is entitled to special enrollment rights under a group health plan, 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 an election for a Health Care Reimbursement Account) provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:

(1) A Participant or Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or

(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).

(c) **Certain Judgments, Decrees and Orders**. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires accident or health coverage (including an election for Health Care Reimbursement) for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), a Participant may (i) change his or her election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage), or (ii) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's

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Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(d) **Medicare and Medicaid**. If a Participant, a Participant's Spouse, or a Participant's Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage (including an election for Health Care Reimbursement) of the person becoming entitled to Medicare or Medicaid. Further, if a Participant, a Participant's Spouse, or a Participant's Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage (including an election for Health Care Reimbursement) of that individual who loses Medicare or Medicaid eligibility.

(e) **Change in Cost**.

The following rules are not applicable to Health Care Reimbursement Accounts under the Plan.

For purposes of this Section 3.05(e), "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 coverage for major medical are considered to be similar coverage. For purposes of this definition, a HCRA is not similar coverage with respect to an accident or health plan that is not a HCRA. This Plan may, in the Plan Administrator's discretion, treat coverage by another employer, such as a Spouse's or Dependent's employer, as similar coverage.

(1) **Increase or Decrease for Insignificant Cost Changes**. Participants are required to increase their elective contributions (by increasing salary reductions or decreasing cash-out amounts, if applicable) to reflect insignificant increases in their required contribution for their Benefit Package Option(s) and decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion, on a uniform and consistent basis 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.

(2) **Significant Cost Increases**. If the Plan Administrator determines that the cost charged to an Employee of a Benefit Package Option(s) significantly increases during a Plan Year, the Participant may either (i) make a corresponding prospective increase in his or her elective contributions (by increasing salary reductions or decreasing cash-out amounts, if applicable), (ii) 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, or (iii) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage.

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The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, on a uniform and consistent basis, whether a cost increase is significant.

(3) **Significant Cost Decreases**. If the Plan Administrator determines that the cost of any Benefit Package Option significantly decreases during a Plan Year, the Plan Administrator may permit the following election changes: (i) Participants who are enrolled in a Benefit Package Option other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect Benefit Package Option that has decreased in cost, and (ii) Employees who are otherwise eligible under Section 2.01 may elect the Benefit Package Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance and on a uniform and consistent basis, whether a cost decrease is significant.

(4) **Limitation on Change in Cost Provisions for DCRA**. The above "Change in Cost" provisions (Sections 3.05(e)(1) – 3.05(e)(3)) apply to DCRA 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(a)(1) through (8), incorporating the rules of Section 152(b)(1) and (2).

(f) **Change in Coverage**.

The following rules are not applicable to Health Care Reimbursement Accounts under the Plan.

The definition of "similar coverage" under Section 3.05(e) also applies to this Section 3.05(f).

(1) **Significant Curtailment**. If coverage is "significantly curtailed" (as defined in subsection (i) below) Participants may elect similar coverage. In addition, as set forth in subsection (ii) below, if the coverage curtailment results in a "Loss of Coverage" (as defined in subsection (iii) below) Participants may drop coverage if no similar coverage is available. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, on a uniform and consistent basis, whether a curtailment is "significant," and whether a Loss in Coverage has occurred.

(i) **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 (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan) during a Plan Year, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package

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Option that provides similar coverage. Coverage under a plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally.

(ii) **Significant Curtailment With a Loss of Coverage**. If the Plan Administrator determines that a Participant's 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, and such curtailment results in a Loss of Coverage during a Plan Year, 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, or drop coverage if no other Benefit Package Option providing similar coverage is available.

(iii) For purposes of this Section 3.05(f)(1), 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, Participant's Spouse or Dependent resides, or a Participant, 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, in its discretion, may treat the following as a Loss of Coverage:

a. 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 a preferred provider network or an HMO).

b. a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant, the Participant's Spouse or the Participant's Dependent is currently in a course of treatment; or

c. any other similar fundamental loss of coverage.

(2) **Addition or Significant Improvement of a Benefit Package Option**. If, during a Plan Year, 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: (i) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their election on a prospective basis to elect the newly added or significantly improved Benefit Package Option, and (ii) Employees who are otherwise eligible under Section 2.01 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. The Plan Administrator (in its sole discretion) will decide, in accordance with

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prevailing IRS guidance and on a uniform and consistent basis, whether there has been an addition or a significant improvement of a Benefit Package Option.

(3) **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, the Participant's Spouse, or the Participant's 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 section 7701(a)(4)), 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).

(4) **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 another employer plan (including a plan of the Employer or another employer), so long as: (i) 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 (ii) the Plan permits Participants to make an election for a Plan Year which is different from the plan year under the other cafeteria plan or qualified benefits plan. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the other employer plan.

Any change in an election affecting Reimbursement Accounts pursuant to this section also will change the maximum reimbursement for the period of coverage remaining in the Plan Year. Such maximum reimbursement for the period of coverage following an election change shall be calculated by adding the balance (if any) remaining in each of the Participant's Reimbursement Accounts as of the end of the portion of the Plan Year immediately preceding the change in election, to the total Plan Contributions scheduled to be made by the Participant during the remainder of such Plan Year to such Account(s).

An Employee who is eligible to become a Participant but declined to become a Participant during the applicable Election Period may become a Participant and file a Pre-tax Contribution election within thirty (30) days of the occurrence of an event described in Section 3.05 above, but only if the election under the new Salary Reduction Agreement is made on account of and corresponds with the event (as described above). A Participant otherwise entitled to make a new election under this Section must do so within thirty (30) days of the event (e.g., Change in Status, significant change in cost or coverage, Medicare or Medicaid eligibility, special enrollment right or judgment, decree, or order).

Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

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3.06 **Impact of Termination of Employment on Election or Cessation of Eligibility**. Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Except as provided below, if revocation occurs under this Section 3.06, no new election with respect to Pre-Tax Contributions may be made by such Participant during the remainder of the Plan Year. Except as otherwise provided in the applicable Benefit Package Options, former Participants who are rehired within thirty (30) days or less of the date of termination of employment will be reinstated with the same election(s) such individual had before termination. If a former Participant is rehired more than thirty (30) days following termination of employment and is otherwise eligible to participate in the Plan, the individual may make a new election.

Expenses may continue to be incurred for such period of time as specified in the Adoption Agreement for Options A and/or B.

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ARTICLE IV

Premium Payments and Credits and Debits to Accounts

4.01 **Source of Benefit Funding**. The cost of coverage under the component Benefit Package Options shall be funded by Participant's Pre-tax and/or After-tax Contributions, Benefit Credits, if provided for in the Adoption Agreement, and any Nonelective Contributions. The component Benefit Package Options, and required contributions thereunder, shall be made known to employees in enrollment materials.

(a) **Participant After-tax and/or Pre-tax Contributions**. Pre-tax or After-tax Contributions (as elected by the Employee) shall equal the contributions required from the Participant (less any Benefit Credits allocated thereto by the Participant, if provided for in the Adoption Agreement, or Nonelective Contributions allocated thereto by the Employer) for coverage of the Participant or the Participant's Spouse or Dependents under the Benefit Package Options elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pre-tax Contributions or After-tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Pre-tax Contributions plus Benefit Credits, if any, and Nonelective Contributions shall not exceed the aggregate cost of the benefits elected.

(b) **Benefit Credits**. The Employer may, but is not required to, make available to Participants Benefit Credits to apply, at the Participant's discretion, towards the cost of one or more of the Benefit Package Options chosen by the Participant. Benefit Credits will be available as set forth in the Adoption Agreement.

(c) **Nonelective Contributions**. The Employer may, but is not required to, contribute Nonelective Contributions on behalf of each Participant for the purpose of providing one or more of the Benefit Package Options under the Plan. Nonelective Contributions will be provided as set forth in the enrollment material.

4.02 **Allocations Irrevocable During Plan Year**. Except as provided in Sections 3.05, 3.06, and 4.03, neither (a) the insurance coverages nor the Pre-Tax Contribution amounts withheld, therefore, (b) the amount to be credited to a Participant Account during the Plan Year pursuant to Sections 4.04 and 4.05, nor (c) the allocation of such amounts to the appropriate Account(s) of the Participant, can be changed during the Plan Year.

4.03 **Reduction of Certain Elections to Prevent Discrimination**. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Pre-tax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

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4.04 **Health Care Reimbursement Accounts**.

(a) **Debiting and Crediting of Accounts**. Each Participant's HCRA (if elected in the Adoption Agreement) will be credited with amounts withheld from the Participant's Compensation for Health Care Reimbursement, Benefit Credits (if any) and Nonelective Contributions by the Employer for HCRA purposes, if any. The Account will be debited for Health Care Reimbursements disbursed to the Participant in accordance with this document. The entire amount elected by the Participant on the Salary Reduction Agreement as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed shall be available to the Participant at any time during the Plan Year without regard to the balance in the Account (provided that the periodic contributions have been made). Thus, the maximum amount of Health Care Reimbursement at any particular time during the Plan Year will not relate to the amount which a Participant has had credited to his or her HCRA. In no event will the amount of Health Care Reimbursements in any Plan Year exceed the annual amount specified for the Plan Year in the Salary Reduction Agreement for Health Care Reimbursement. Any amount credited to the Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Health Care Reimbursement within such number of days following the end of the Plan Year for which the election was effective as shall be selected in the Adoption Agreement. Amounts so forfeited shall be used to offset administrative expenses or any use that is permitted within the applicable Department of Labor or Internal Revenue Service regulations.

(b) **Source of Payments**. All Health Care Reimbursements derived hereunder shall be paid exclusively from the amounts in each Employee's HCRA funded by amounts withheld from the Employee's Compensation for HCRA purposes, Benefit Credits for HCRA purposes (if any) and Nonelective Contributions by the Employer for HCRA purposes (if any). In the event that an Employee's claim for Health Care Reimbursement benefits exceeds the amount currently available in the Employee's HCRA, the Employer shall pay the excess amount up to the amount elected by the Participant on the Salary Reduction Agreement for Health Care Reimbursement less any reimbursements already disbursed. Future Salary Reductions from the Employee shall then go to the Employer as reimbursement for the money so advanced on behalf of the Employee.

(c) **Employer Risk**. If the Employee terminates employment before the Employer has been reimbursed for the money it has advanced on behalf of the Employee, the entire unreimbursed portion shall be deemed to be an "administrative expense" to be refunded to the Employer only by any unused Account balance(s) (if any) as provided in Section 4.04(a).

4.05 **Dependent Care Reimbursement**.

(a) **Crediting and Debiting of Accounts**. Each Participant's DCRA (if elected in the Adoption Agreement) will be credited with amounts withheld from the Participant's Compensation for Dependent Care Reimbursement, Benefit Credits (if any) and Nonelective Contributions by the Employer for DCRA purposes (if any). The Account will be debited for Dependent Care Reimbursements disbursed to the Participant in accordance with this document. In the event that the amount in

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the Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months (within the same Plan Year), to be paid out as the DCRA balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the DCRA for any Plan Year. Any amount allocated to the DCRA shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Dependent Care Reimbursement for the Plan Year within such number of days following the end of the Plan Year for which the election was effective as shall be selected in the Adoption Agreement. Amounts so forfeited shall be used to offset administrative costs or any use that is permitted within the applicable Internal Revenue Service regulations.

(b) **Source of Payments**. All Dependent Care Reimbursement benefits derived hereunder shall be paid exclusively from the amounts in each Employee's DCRA funded by amounts withheld from the Employee's Compensation pursuant to the Salary Reduction Agreement for Dependent Care Reimbursement, Benefit Credits allocable thereto (if any), and Nonelective Contributions allocated by the Employer for Dependent Care Reimbursement Benefits (if any).

4.06 **Debit or Stored-Value Card**. If elected by the Employer in its Adoption Agreement, a debit or stored value card ("card") shall be available for Participant use to pay eligible HCRA expenses, subject to a provider's ability to accept a card. If a card is provided, under no circumstances shall the Employer have any responsibility for a payment which is denied when the Participant attempts to use a card and thereby obtain paperless adjudication of claims.

The Employer shall establish such policies, procedures and guidelines as shall assure that the substantiation requirements of Code section 125 and regulations promulgated thereunder, as well as all other applicable IRS guidance, are satisfied.

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ARTICLE V

Benefits

5.01 **Qualified Benefits**. The maximum benefit a Participant may elect under this Plan shall not exceed the sum of (i) the maximum Health Care Reimbursement under Section 5.01(a) (if elected in the Adoption Agreement) and (ii) the maximum Dependent Care Reimbursement under Section 5.01(b) (if elected in the Adoption Agreement). The Qualified Benefits available for election are one or more of the following:

(a) **Health Care Reimbursement**. If elected in the Adoption Agreement, payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his or her Dependents while he or she is an Employee, during the Plan Year for which the Participant's election is effective. These expenses must also be expenses which --

(1) are not covered, paid or reimbursed from any other source; and

(2) meet the criteria of tax deductibility as a medical or dental expense under Code Section 213, as amended and the regulations thereunder, and

(3) will not be taken as a deduction from income on the Participant's federal income tax return in any tax year; and

(4) do not exceed the amount that the Employee has elected to have credited to a HCRA for Health Care Reimbursement for the Plan Year less previous Health Care Reimbursements made during the Plan Year. The minimum and maximum amounts an Employee who elects Health Care Reimbursement Benefits may elect to have credited to a Health Care Reimbursement Account for a Plan Year is as indicated in the Adoption Agreement;

(5) are verified in writing to the satisfaction of the Administrator that a covered expense has been incurred with respect to which a Claim Form which meets the substantiation requirements of Section 6.10 has been submitted.

(b) **Dependent Care Reimbursement**. If elected in the Adoption Agreement, payment shall be made to the Participant in cash as reimbursement for Eligible Employment-Related Expenses incurred by him or her while an Employee, during the Plan Year for which the Participant's election is effective, provided that the substantiation requirements of Section 6.10 have been complied with. No payment otherwise due a Participant hereunder shall exceed the smallest of:

(1) the Participant's Compensation for the applicable month; or

(2) the Earned Income of the Participant's Spouse for such month (Note: a Spouse of a Participant who is not employed during a month in which the Participant incurs Eligible Employment-Related Expenses and who is either incapacitated or a Student shall be deemed to have Earned Income in the amount of $200 per month per Qualifying Individual for whom the

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Participant incurs Eligible Employment-Related Expense(s), up to a maximum amount of $400 per month); or

(3) the amount the Participant has actually contributed to a Dependent Care Reimbursement Account for Dependent Care Reimbursement for the Plan Year less any prior Dependent Care Reimbursements during the Plan Year; or

(4) Five Thousand Dollars ($5,000), or, if the Participant is married and files a separate tax return, Two Thousand Five Hundred Dollars ($2,500) (or any future aggregate limitations promulgated under Code Section 129) less any prior reimbursements during the Plan Year.

5.02 **Cash Benefit**. To the extent that a Participant does not elect to have the maximum amount of his or her Compensation contributed as a Pre-tax Contribution or After-tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, however, that any applicable Nonelective Contributions and/or Benefit Credits may not be received in the form of cash compensation.

5.03 **Repayment of Excess Reimbursements**. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses and/or Eligible Employment-Related Expenses that have been substantiated by such Participant during the Plan Year as required by Section 6.10 hereof, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

5.04 **Termination of Reimbursement Benefits**. Coverage under the HCRA and/or DCRA shall cease as of the day in which a Participant is no longer employed by the Employer or when a premium payment for the respective plan(s) has been missed for any reason. Provided, however that Participants may submit claims for reimbursement for Eligible Employment-Related Expenses arising during the Plan Year at any time during the run-out period selected in the Adoption Agreement after the end of the Plan Year for which the election had been in effect, and to receive reimbursement hereunder. Participants in the HCRA may submit claims for reimbursement for Eligible Medical Expenses arising during the Plan Year and before the date of separation from service at any time during the run-out period selected in the Adoption Agreement after the end of the Plan Year for which the election had been in effect, and to receive reimbursement hereunder. Unless a COBRA election is made, Participants shall not be entitled to receive reimbursement for medical care expenses incurred after coverage ceases under this Section. Any unused reimbursement benefits at the expiration of the run-out period selected in the Adoption Agreement following the close of the Plan Year shall be treated in accordance with Section 4.04 or 4.05.

5.05 **COBRA Coverage**. Each Benefit Package Option made available under the Employer's Plan that is considered to be a "group health plan" under Code Section 4980B, because employees and their families are provided with health care benefits within the meaning of Code Section 213(d)(1), including the HCRA, shall contain the necessary provisions required by Code Section 4980B and ERISA Section 601, to ensure that such benefits may be continued, to the extent required by Code Section 4980B, on or after the occurrence of the qualifying events defined in Code Section 4980B(f)(3).

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5.06 **Coordination of Benefits Under HCRA**. The HCRA is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

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ARTICLE VI

Plan Administration

6.01 **Allocation of Authority**. The Board of Directors (or an authorized officer of the Employer), or in the case of a governmental employer, the appropriate governing body, shall appoint a Committee (the Plan Administrator) which shall keep the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and other documents related to the Plan. In the case of an insured Benefit Package Option, the insurer shall be the named fiduciary with respect to benefit claim determinations thereunder, and with respect to benefit claims shall have all of the powers of the Plan Administrator described herein. 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 powers and duties:

(a) To require any person to furnish such reasonable information as he or she may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he or she shall deem necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;

(d) To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer or insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;

(e) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan;

(f) To keep records of all acts and determinations, and to keep all such records, books of account, data and other documents as may be necessary for the proper administration of the Plan; and

(g) To do all things necessary to operate and administer the Plan in accordance with its provisions.

6.02 **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 and to rely upon all tables, valuations, certificates, reports and opinions furnished thereby. Unless otherwise

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provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

6.03 **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.

6.04 **Compensation of Plan Administrator**. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who 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 his or her duties shall be paid by the Employer.

6.05 **Bonding**. Unless otherwise determined by the Employer, or unless required by any federal or state law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

6.06 **Payment of Administrative Expenses**. All reasonable expenses incurred in administering the Plan shall be paid as indicated in the Administrative Service Agreement.

6.07 **Funding Policy**. The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type which may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and shall be retained by the Employer. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided herein. Such limitation shall include, but not be limited to, losses or obligations which pertain to the following:

(a) Once insurance is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer;

(b) To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which results from such failure;

(c) The Employer will not be liable for the payment of any insurance premium or any loss which may result from the failure to pay an insurance premium if the benefits available hereunder are not enough to provide for such premium cost at the time it is due. In such circumstances, the Employee will be responsible for and see to the payment of such premiums. The Employer will undertake to notify a Participant if available benefits hereunder are not enough to provide for an insurance premium, but will not be liable for any failure to make such notification;

(d) When employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise herein, and the Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

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6.08 **Disbursement Reports**. The Plan Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's general assets pursuant to the provisions of the Plan.

6.09 **Indemnification**. The Plan Administrator shall be indemnified by the Employer against claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan, except claims arising from gross negligence, willful neglect, or willful misconduct.

6.10 **Substantiation of Expenses**. Except as provided in Section 4.06 when a debit or stored-value card is used and different substantiation requirements apply, each Participant must submit a written Claim Form (on a form provided by the Plan Administrator) to the Plan Administrator to receive reimbursement for an incurred expense. The Claim Form shall be accompanied by a written statement/bill from an independent third party stating that the expense has been incurred and the amount thereof. The forms shall contain such evidence as the Plan Administrator shall deem necessary to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed.

6.11 **Reimbursement**. Reimbursements shall be made as soon as administratively feasible after the required forms and supporting information have been received by the Plan Administrator. Year-end expense reimbursement claims must be submitted to the Plan Administrator within such number of days as shall be specified in the Adoption Agreement after the close of the Plan Year for which the Salary Reduction Agreement is effective, and during which such expense was incurred in order to be eligible for reimbursement. Likewise, if a Participant terminates participation in the Plan with a credit balance in any Reimbursement Account, such Participant shall be entitled to submit to the Plan Administrator any claims for reimbursement for reimbursable expenses incurred prior to such cessation of Participation at any time within such number of days as shall be specified in the Adoption Agreement after the close of the Plan Year for which the Salary Reduction Agreement is effective. Terminated Participants shall have such additional number of days after the end of the Plan Year to incur expenses as shall be specified in the Adoption Agreement.

6.12 **Statements**. The Plan Administrator may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing Health Care and Dependent Care Reimbursement and the respective Reimbursement Account balance(s).

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ARTICLE VII

Funding Agent

The Plan shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and shall comply with all applicable regulations promulgated by the Department of Labor ("DOL"), taking into consideration any enforcement procedures adopted by the DOL.

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ARTICLE VIII

Claims Procedures (Applicable to Non-Governmental Plans)

8.01 **Application to Plan Benefits**. This Article shall not apply to benefits under the component Benefit Package Options, but shall only apply to issues germane to the benefits available under this Plan (i.e., such as a determination of: a Change in Status; change in cost or coverage; or eligibility and participation matters under this Plan document). This Article shall be the claims procedure applicable to the Health Care Reimbursement and the Dependent Care Reimbursement Plan(s).

8.02 **Procedure if Benefits Are Denied Under the Plan**. Any Employee, beneficiary, or his or her duly authorized representative may file a claim for a benefit to which the claimant believes that he or she is entitled, but that has been previously denied by the Plan Administrator. Such a claim must be in writing and delivered to the Plan Administrator in person or by mail, postage prepaid. Within thirty (30) days after receipt of such claim, the Plan Administrator shall send to the claimant, by mail, postage prepaid, notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed thirty (30) days from the end of the initial period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial 30-day period. The Plan Administrator shall have full discretion to deny or grant a claim in whole or in part. If notice of the denial of a claim is not furnished in accordance with this Section 8.02, the claim shall be deemed denied and the claimant shall be permitted to exercise his or her right to review pursuant to Sections 8.04 and 8.05.

8.03 **Requirement for Written Notice of Claim Denial**. The Plan Administrator shall provide a written notice to every claimant who is denied a claim for benefits under this Article. Such written notice shall set forth in a manner calculated to be understood by the claimant, the following information:

(a) The specific reason or reasons for the denial;

(b) Specific reference to pertinent Plan provisions on which the denial is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary, and

(d) An explanation of the Plan's claim review procedure.

8.04 **Right to Request Hearing on Benefit Denial**. Within sixty (60) days (180 days in the case of a claim for HCRA benefits) after the receipt by the claimant of written notification of the denial (in whole or in part) of his or her claim, the claimant or his or her duly authorized representative may make a written application to the Plan Administrator, in person or by certified mail, postage prepaid, to be afforded a review of such denial; may review pertinent documents; and may submit issues and comments in writing.

8.05 **Disposition of Disputed Claims**. Upon receipt of a request for review, the Plan Administrator shall make a prompt decision on the review matter. The decision on such review shall be written in a manner calculated to be understood by the claimant and shall

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include specific reasons for the decision and specific references to the pertinent plan or insurance policy provisions on which the decision was based. The decision upon review shall be made not later than sixty (60) days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than one hundred twenty (120) days after receipt of a request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial sixty (60)-day period. If notice of the decision on the review is not furnished in accordance with this Section, the claim shall be deemed denied and the Claimant shall be permitted to exercise his or her right to a legal remedy.

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ARTICLE IX

Amendment of Termination of Plan

9.01 **Permanency**. While the Employer fully expects that this Plan will continue indefinitely, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 9.02 and 9.03, below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

9.02 **Employer's Right to Amend**. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Committee in accordance with its normal procedures for transacting business or by written consent of all Committee members. Alternatively, amendments may be made by the Employer or its Board of Directors or other governing body. Such amendments may apply retroactively or prospectively. Each Benefit Package Option shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer.

9.03 **Employer's Right to Terminate**. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Board of Directors (or a duly authorized officer of the Employer) or by the Employer's governing body in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

9.04 **Determination of Effective Date of Amendment or Termination**. Any such amendment, discontinuance or termination shall be effective as of such date as the Employer shall determine. Subject to Sections 4.04(a) and 4.05(a), no amendment, discontinuance or termination shall allow the return to the Employer of any Reimbursement Account balance nor its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries.

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ARTICLE X

General Provisions

10.01 **Not an Employment Contract**. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with the Employer.

10.02 **Applicable Laws**. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the State identified in the Adoption Agreement to the extent not preempted.

10.03 **Post-Mortem Payments**. Any benefit payable under the Plan after the death of a Participant shall be paid to his or her surviving Spouse, otherwise, to his or her estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

10.04 **Non-Alienation of Benefits**. Except as expressly provided by the Plan Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

10.05 **Mental or Physical Incompetency**. Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his or her estate has been appointed.

10.06 **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 the Plan Administrator cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited after a reasonable time after the date any such payment first became due.

10.07 **Requirement for Proper Forms**. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

10.08 **Source of Payments**. The Employer and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

10.09 **Multiple Functions**. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

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10.10 **Tax Effects**. Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any salary reductions or payments made hereunder made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If, for any reason, it is determined that any amount paid for the benefit of a Participant or beneficiary is includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employee as a result thereof. The Plan is designed and is intended to be operated as a "cafeteria plan" under Code Section 125.

10.11 **Gender and Number**. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

10.12 **Headings**. The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

10.13 **Incorporation by Reference**. The actual terms and conditions of the separate component Benefit Package Options offered under this Plan are contained in separate, written documents governing each respective benefit and shall govern in the event of a conflict between the individual plan document and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

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

10.15 **Effect of Mistake**. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as 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 the Plan or the Employer from Compensation paid by the Employer.

10.16 **Forfeiture of Unclaimed Reimbursement Account Benefits**. Any Reimbursement Account payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Health or Dependent Care Expense was incurred shall be forfeited.

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ARTICLE XI

Continuation Coverage Under COBRA

The following provisions shall be applicable to the HCRA, and any other group health plan (as defined by Code section 4980B and 5000(b)(1) and the regulations promulgated thereunder) subject to COBRA that does not otherwise contain COBRA provisions. As noted in Section 11.05, COBRA coverage need not be extended to certain HCRA Participants. The intent of this Article is to extend only those continuation rights required by COBRA. To the extent greater rights are provided for hereunder, this Article shall be void.

Nothing herein shall require the Employer, if it is not otherwise subject to the COBRA requirements of the Code or any similar law, to comply with the requirements of such law.

11.01 **Continuation Coverage after Termination of Normal Participation**. During any Plan Year during which the Employer is subject to Code Section 4980B, each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under the HCRA (or other group health plan subject to COBRA) upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage hereunder. Such extended coverage under the plan is known as "Continuation Coverage."

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

11.03 Who is not a "Qualified Beneficiary." A person is not a Qualified Beneficiary if, as of such day, either the individual is covered under the Health Care Reimbursement Plan (or other group health plan subject to COBRA) by virtue of the election of Continuation Coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event, or is entitled to Medicare coverage under Title XVIII of the Social Security Act. Furthermore, an individual who fails to elect Continuation Coverage within the election period provided in Section 11.08, below, shall not be considered to be a Qualified Beneficiary.

11.04 What is a "Qualifying Event." Any of the following shall be considered as a "Qualifying Event":

(a) death of a Covered Employee;

(b) termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment;

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(c) divorce or legal separation of a Covered Employee from the employee's Spouse;

(d) a Covered Employee becoming entitled to receive Medicare benefits under Title XVIII of the Social Security Act; or

(e) a dependent child of a Covered Employee ceasing to be a Dependent.

In the case of any person treated as a "Covered Employee" but who is not a common-law employee, termination of "employment" means termination of the relationship that originally gave rise to eligibility to participate in the Health Care Reimbursement Plan (or other group health plan subject to COBRA).

11.05 **COBRA Not Applicable to Certain HCRA Participants**. In accordance with IRS regulations, COBRA continuation coverage will not be offered to HCRA participants under certain circumstances:

(a) **Unavailability of COBRA in Subsequent Plan Years**. COBRA continuation will not be offered to a HCRA Participant in any Plan Year following the Plan Year in which the Qualifying Event occurs if:

(1) **HCRA is Exempt from HIPAA**. The HCRA is exempt from HIPAA (i.e., a major medical plan is available in addition to the HCRA, and the HCRA benefit does not exceed two times the salary reduction or, if greater, the salary reduction plus $500; and

(2) **COBRA Premium Equals or Exceeds HCRA Benefit**. If for the plan year in which the Qualifying Event occurs, the maximum amount the Qualified Beneficiary could be required to pay for a full year of HCRA COBRA coverage equals or exceeds the maximum benefit available to the Qualified Beneficiary for the plan year.

(b) **Unavailability of COBRA in Plan Year in which Qualifying Event Occurs**. COBRA continuation coverage will not be offered to a Qualified Beneficiary in the Plan Year in which the Qualifying Event occurred if:

(1) **Conditions in Section 11.05(a) are Satisfied**. The HCRA satisfies the conditions set forth in Section 11.05(a); and

(2) **Participant's Reimbursement Account Has a Deficit at the Time of the Qualifying Event**. Taking into account all claims submitted on or before the date of the Qualifying Event, the Qualified Beneficiary's remaining HCRA balance for the Plan Year is less than the maximum required COBRA premiums for the rest of the year -- i.e., the Participant's Reimbursement Account is in a deficit position.

The Plan Administrator will notify HCRA Participants as to their COBRA eligibility (if any).

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11.06 **What Benefit is Available under Continuation Coverage**. Each person who is eligible to elect to continue coverage under this Article shall have the right to continue the level of coverage in effect for the Covered Employee on the day before the Qualifying Event (or a lesser level of coverage). A premium for Continuation Coverage shall be charged to Employees and Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by applicable law.

11.07 **Notice Requirements**.

(a) When an Employee becomes covered under this HCRA (or any other group health plan subject to COBRA), the Plan Administrator must inform the Participant (and Spouse, if any) in writing of the rights to continued coverage, as described in Article XI.

(b) The Employer shall give the Plan Administrator (if different from the Employer) written notice of a Qualifying Event within thirty (30) days of the occurrence thereof.

(c) Within fourteen (14) days of receipt of the Employer's notice, the Plan Administrator shall furnish each Qualifying Beneficiary with written notification of the termination of regular coverage under the HCRA (or any other group health plan subject to COBRA), as well as a recital of the rights of any such Beneficiary to elect Continuation Coverage as required by Code Section 4980B and ERISA Section 601, in accordance with the terms of this Plan.

(d) In the case of a Qualifying Event described in Section 11.04(c) or (e), a Covered Employee or a Qualified Beneficiary who is a Spouse or Dependent of such Employee must notify the Plan Administrator within sixty (60) days of the later of the occurrence thereof or the date coverage is lost as a result of the occurrence thereof. The Plan Administrator shall give written notification of Continuation Coverage rights to any other affected Qualified Beneficiaries within fourteen (14) days of receipt of the notice described in this Section 11.07(d).

Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a Spouse of a Covered Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

11.08 **Election Period**. Any Qualified Beneficiary entitled to Continuation Coverage shall have 60 days from the later of the date of the notice required by Section 11.07 or the date coverage terminates as a result of the Qualifying Event in which to return a signed election to the Plan Administrator indicating the choice to continue benefits under this Plan.

11.09 **Duration of Continuation Coverage**. Except as otherwise provided in this Plan, Continuation Coverage shall extend for a period of 18 months after the date that regular coverage ceased due to occurrence of the initial Qualifying Event described in Section 11.04(b), unless during such 18-month period a subsequent Qualifying Event occurs, in which case, another election to extend coverage for 18 months shall be available to the Beneficiary. Except as otherwise provided in this Section, in the case of a Qualifying Event not described in Section 11.04(b), Continuation Coverage shall extend for a period of 36 months after the date that regular coverage ceased due to the occurrence of the Qualifying Event. In the case of a Qualified Beneficiary who is determined, under Title II or XVI of

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the Social Security Act, to have been disabled within 60 days of a Qualifying Event, described in Section 11.04(b), Continuation Coverage with respect to such event shall extend for a period of 29 months after the date that regular coverage ceased due to the occurrence of the Qualifying Event if the Qualified Beneficiary has provided notice of such determination within sixty (60) days after the date of such determination and before the end of the initial 18 month Continuation Coverage period. In the event a Covered Employee becomes entitled to Medicare coverage, the period of Continuation Coverage for a Qualified Beneficiary, other than the Covered Employee for such Qualifying Event or any subsequent Qualifying Event, shall not terminate for a period of 36 months from the date the Covered Employee becomes entitled to Medicare benefits. In no event, however, shall Continuation Coverage extend more than 36 months beyond the date of the original Qualifying Event.

11.10 **Automatic Termination of Continuation Coverage**. Continuation Coverage shall automatically cease if (a) the Employer no longer offers the particular group health coverage to any of its employees, (b) the required premium for Continuation Coverage for a particular coverage is not paid within 30 days of the date due or within 45 days after the initial election of Continuation Coverage made pursuant to Section 11.08 (whichever is later), (c) an electing Qualified Beneficiary becomes covered under another group health plan other than a group health plan which may limit a Qualified Beneficiary's coverage because it involves a preexisting condition, or (d) an electing Qualified Beneficiary becomes eligible to receive benefits under Medicare.

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IRS Circular 230 Notice: We are required to advise you no person or entity may use any tax advice in this communication or any attachment to (i) avoid any penalty under federal tax law or (ii) promote, market or recommend any purchase, investment or other action.

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