TOWN OF ALLENSTOWN
SECTION 125 FLEXIBLE BENEFITS PLAN DOCUMENT

TABLE OF CONTENTS

ARTICLE 1. INTRODUCTION

Section 1.01 PLAN

This Section 125 Flexible Benefits Plan Document and its related Adoption Agreement are intended to qualify as a cafeteria plan within the meaning of Code section 125 and is to be interpreted in a manner consistent with the requirements of such Code section. To the extent provided in the Adoption Agreement, the Plan provides for the pre-tax payment of premiums and contributions to spending accounts that are excludable from gross income under Code section 125, reimbursement of certain medical expenses that are excludable from gross income under Code section 105(b), reimbursement of certain dependent care expenses that are excludable from gross income under Code section 129, and/or for such other Benefits as set forth herein.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Employer on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Employer whose employment terminated prior to the Effective Date shall be determined under the provisions of the Plan as in effect from time to time prior to that date.

ARTICLE 2. DEFINITIONS

The following specially capitalized words and phrases used in this Section 125 Flexible Benefits Plan Document and the Adoption Agreement have the respective meanings set forth below unless a different meaning is clearly required by the context.

Account means
the bookkeeping balance of an account established for each Participant as of the applicable date. "Account" or "Accounts" shall include, to the extent provided in the Adoption Agreement, a Premium Conversion Account, a General Purpose Health Flexible Spending Account, an HSA-Compatible Health Flexible Spending Account, a Dependent Care Assistance Plan Account, and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate. Any account so established will be merely a recordkeeping account.

Adoption Agreement means
the document executed in conjunction with this Section 125 Flexible Benefits Plan Document that contains the optional features selected by the Plan Sponsor. The Adoption Agreement is incorporated herein and forms a part of the Plan.

Affiliate means
the Plan Sponsor or any other employer required to be aggregated with the Plan Sponsor under Code sections 414(b), (c), (m) or (o); provided, however, that "Affiliate" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

Benefit(s) means
the benefit option(s) available to Eligible Employees under the Plan as selected in the Adoption Agreement.

Cash Opt-Out Benefit means
the Benefit option described in Section 11.02 that, if offered by the Employer, allows an Eligible Employee to receive a cash payment in lieu of receiving coverage under the Employer's group health plan or other welfare benefit plan specified in the Adoption Agreement.

COBRA means
the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and applicable regulations issued thereunder.

Code means
the Internal Revenue Code of 1986, as amended from time to time, and applicable regulations issued thereunder.

Compensation means
the cash wages or salary paid to a Participant.

Contract means
an insurance policy, contract, self-funded arrangement and/or Employer group health, disability or other welfare plan under which a Participant is eligible to receive benefits regardless of whether such policy, contract, arrangement or plan is related to any Benefit offered hereunder. "Contract" shall not include any product which is advertised, marketed, or offered as long-term care insurance. "Contract" shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.

Debit Card means
a prepaid benefits card that may be used by a Participant as a means of paying for eligible Health FSA and/or DCAP Account Expenses

Dependent means

(i) for Health FSA purposes, any individual who, within the meaning of Code section105(b), is either (a) a dependent of the Participant or (b) a child of the Participant who as of the end of the taxable year has not attained age 27;

(ii) for DCAP Account purposes, any individual who is a tax dependent of the Participant as defined generally in Code section 152, and also an individual described in Code section 21(e)(5) (i.e., a child of divorced parents shall be considered a dependent of the parent with whom the child shared the same principal place of abode for the greater portion of the calendar year); and

(iii) for Premium Conversion Account purposes, any individual who is eligible for coverage as a dependent of the Participant under the terms of the Employer group medical or dental plan or other Contract with respect to which the Premium Conversion Account is offered; provided, however, that the Participant's portion of any premium cost related to coverage of a Non-Tax Dependent may not be contributed on a pre-tax basis through a Salary Reduction Agreement unless the Employer has elected in the Adoption Agreement to include Section 5.06 of the Plan relating to Coverage for Non-Tax Dependents.

Notwithstanding the foregoing, the Premium Conversion Account and Health FSA components of the Plan will provide benefits in accordance with the applicable requirements of any qualified Medical Child Support Order, even if the child does not otherwise meet the above definition of "Dependent."

Dependent Care Assistance Plan Account or DCAP Account or Dependent Care Account means
the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan pursuant to Article 8.

Dependent Care Assistance Plan Account (DCAP Account) Experience Gains means
with respect to a Plan Year, the total amount of contributions (including salary reduction contributions, non-elective Employer contributions and Flex Credits) made to DCAP Accounts minus the total amount of eligible DCAP Account expenses reimbursed for the Plan Year.

Effective Date means
the date this Plan Document became effective as set forth in Part A of the Adoption Agreement, provided that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.

Eligible Employee means
an Employee who satisfies the eligibility requirements established by an Employer, including any applicable Probationary Period, as set forth in the Adoption Agreement. Eligible Employees for purposes of participation in a Health FSA component of the Plan must be limited to classes of employees who are also eligible for other group health plan coverage (not limited to "excepted benefits" as defined in 45 CFR 146.145(c)) through the Employer. Eligible Employee includes a former Eligible Employee for the limited purpose of allowing continued eligibility for Benefits under the Plan as and if required by COBRA or other applicable law.

If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Employer is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Employer in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

An individual who becomes employed by an Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the other entity shall not become eligible to participate in the Plan until the Employer or Plan Sponsor specifically authorizes such participation.

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 the following:

(i) Any leased employee (including but not limited to those individuals defined as leased employees in Code section 414(n)), or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee for the period during which such individual is so classified, whether or not such individual is on the employer's W-2 payroll;

(ii) Any individual performing services for the Employer but who is paid by a temporary or other employment or staffing agency, for the period during which such individual was paid by such agency; and

(iii) Any self-employed individual.

Employer means
the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

Enrollment Form means
the form (paper or electronic) submitted by an Eligible Employee to the Employer to elect Benefits under the Plan and shall include any Salary Reduction Agreement.

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

Flex Credits means
the Employer contributions described in Section 11.01 of the Plan.

FMLA means
the Family and Medical Leave Act of 1993, as amended from time to time, and applicable regulations pertaining thereto.

FSA Administrator means
HealthTrust, Inc. (and/or its subcontractor), the entity that has been hired by the Plan Sponsor to perform certain administrative services on behalf of the Plan Sponsor with respect to the Plan, including processing of claims for reimbursement under the Health FSA and DCAP Account components. The Employer is solely responsible for administration of the Premium Conversion Account, Cash Opt-Out and HSA Contributions Benefits under the Plan.

Grace Period means
the designated period following a Plan Year during which a Participant who has unused benefits or contributions relating to a Health FSA or DCAP Account from the immediately preceding Plan Year and who incurs expenses for that same Benefit during the period, may be paid or reimbursed for those expenses as if the expenses had been incurred in the immediately preceding Plan Year. If the Employer has elected in the Adoption Agreement to provide a Grace Period for a Health FSA and/or DCAP Account, then such Grace Period shall extend through the 15th day of the third calendar month after the end of the applicable Plan Year and shall be considered part of the Period of Coverage with respect to that Plan Year.

General Purpose Health Flexible Spending Account or General Purpose Health FSA means
the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Article 6.

General Purpose Health FSA Experience Gains means
with respect to a Plan Year, the total amount of contributions (including salary reduction contributions, non-elective Employer contributions, Flex Credits, and carryovers from the prior Plan Year) made to General Purpose Health FSAs minus (i) the total amount of eligible General Purpose Health FSA expenses reimbursed for the Plan Year and (ii) the total amount of carryovers from the current Plan Year (if the carryover provision has been selected in the Adoption Agreement).

Health Flexible Spending Account or Health FSA means
the General Purpose Health FSA and/or HSA-Compatible Health FSA established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Article 6 and Article 7, as applicable.

Health Savings Account or HSA means
a health savings account described in, and to which contributions may be made pursuant to, Article 9.

Highly Compensated Employee means
an Employee described in Code section 414(q).

Highly Compensated Individual means
an individual within the meaning of Code section 105(h)(5).

HIPAA means
the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable privacy and security regulations issued thereunder.

HRA means
a health reimbursement arrangement subject to Code section 105.

HSA-Compatible Health Flexible Spending Account or HSA-Compatible Health FSA means
a Limited Purpose Health Flexible Spending Account.

HSA-Compatible Health FSA Experience Gains means
with respect to a Plan Year, the total amount of contributions (including salary reduction contributions, non-elective Employer contributions, Flex Credits, and carryovers from the prior Plan Year) made to HSA-Compatible Health FSAs minus (i) the total amount of eligible HSA-Compatible Health FSA expenses reimbursed for the Plan Year and (ii) the total amount of carryovers from the current Plan Year (if the carryover provision has been selected in the Adoption Agreement).

Key Employee means
an Employee described in Code section 416(i).

Leased Employee means
an Employee described in Code section 414(n)(2).

Limited Purpose Health Flexible Spending Account or Limited Purpose Health FSA means
the Account established with respect to the Participant's election to have medical expenses, as described in Section 7.05(b)(1), reimbursed by the Plan pursuant to Article 7.

Medical Child Support Order means
in accordance with New Hampshire RSA 161-H:1, any valid judgment or order to provide health coverage for a dependent child of the Eligible Employee issued by any court or administrative body of the State of New Hampshire or any other state including an order and a final decree of divorce.

Non-Tax Dependent means
any individual who is eligible for coverage under the terms of the Employer's group medical and/or dental plan as a dependent of the Participant, but is not the Participant's Spouse or Dependent (as defined for Health FSA purposes).

Open Enrollment Period means
the period prior to the beginning of each Plan Year during which each Eligible Employee will be allowed to enroll in or modify his or her election with respect to available Benefits for the upcoming Plan Year. Any Eligible Employee who has previously elected not to participate in the Plan, or one of the available Benefits, may change their enrollment election for the upcoming Plan Year by submitting an Enrollment Form to the Plan Administrator during the Open Enrollment Period prior to the beginning of that Plan Year.

Participant means
an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

Period of Coverage means
the Plan Year, including any applicable Grace Period, except that (i) for Employees who first become eligible to participate during a Plan Year, it shall mean the portion of the Plan Year including and following the date participation commences, and (ii) for Participants who terminate participation during a Plan Year, it shall mean the portion of the Plan Year prior to the date participation terminates in accordance with Section 3.04 of the Plan.

Plan means
the Section 125 Flexible Benefits Plan as identified in the Adoption Agreement and as described in the Plan Document as amended from time to time.

Plan Administrator means
the Plan Sponsor (or such other person(s) designated by the Plan Sponsor pursuant to the Adoption Agreement and Section 14.01 to administer the Plan).

Plan Document means
this Section 125 Flexible Benefits Plan Document, the Adoption Agreement, and any other materials pertinent to the Plan and its administration, which are incorporated herein by this reference.

Plan Sponsor means
the entity described in the Adoption Agreement that maintains the Plan.

Plan Year means
the 12-consecutive month period described in Part A of the Adoption Agreement.

Premium Conversion Account means
the Account established with respect to the Participant's election to have premiums reimbursed by the Plan pursuant to Article 5.

Probationary Period means
the period of time established by the Employer that an Employee must work before becoming an Eligible Employee under the Plan.

Run-out Period means
the ninety (90) day period, or such other period set forth in the Adoption Agreement, after any Period of Coverage during which a Participant may submit claims for reimbursement from their Health FSA or DCAP Account.

Salary Reduction Agreement means
the agreement pursuant to which an Eligible Employee elects to reduce his or her Compensation and instead receive a Benefit provided under the Plan.

Spouse means
an individual who is legally married to an Eligible Employee as determined under state or federal law (and who is treated as a spouse under the Internal Revenue Code).

Termination and Termination of Employment means
any absence from service that ends the employment of an Employee with the Employer.

ARTICLE 3. ELIGIBILITY

Section 3.01 ELIGIBLE EMPLOYEES

To be eligible to participate in this Plan and one or more of the Benefits, an individual must meet the definition of Employee and must satisfy the eligibility requirements established by his or her Employer, including any applicable Probationary Period, as set forth in the Adoption Agreement. Following satisfaction of the eligibility requirements and provided the Employee is certified as being an Eligible Employee by the Employer, an Eligible Employee may elect to participate in the Plan in accordance with Article 4.

Employees who satisfy the eligibility requirements as of the Effective Date are automatically Eligible Employees and may enroll immediately as of the Effective Date. Notwithstanding the foregoing, an Eligible Employee shall be eligible to make elections only for the Benefits as are specifically authorized in the Adoption Agreement.

Section 3.02 INELIGIBLE EMPLOYEES

Notwithstanding anything herein to the contrary, the Employees identified in the Adoption Agreement as excluded Employees are not Eligible Employees and may not participate in any Benefit under the Plan.

Section 3.03 LEAVE OF ABSENCE

(a) FMLA Leave of Absence. The following rules apply only with respect to qualifying Employees of an Employer that is subject to FMLA requirements. These rules are intended to comply with applicable requirements of the FMLA and shall be interpreted and applied accordingly.
   (1) *Health Benefits.* If a Participant takes a leave of absence under FMLA, the Participant shall be entitled to continue to participate in and the Employer shall continue to maintain those Benefits under the Plan that provide health care, including the Premium Conversion Account for payment of premiums applicable to health care, the Health FSA, and Flex Credits, if applicable, as if the Participant were not on FMLA leave. If required, or otherwise elected, a Participant taking paid FMLA leave will pay his or her share of premiums on a pre-tax basis by salary reduction as if he or she was not taking FMLA leave. A Participant may also elect to continue coverage but discontinue contributions for the period of the FMLA leave of absence, as set forth in the Adoption Agreement. During an unpaid FMLA leave of absence, a Participant may elect to revoke coverage. If a Participant elects to revoke coverage during the unpaid FMLA leave of absence, the coverage will be reinstated under the same terms upon the Participant's return from the FMLA leave of absence.
   (2) *Non-Health Benefits.* A Participant shall not be entitled to continue to participate in Benefits under the Plan that do not provide health care except to the extent provided in the Adoption Agreement or in accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave. Participant contributions for Benefits during a leave of absence under FMLA shall be determined by the Plan Administrator in accordance with Code section 125.

(b) Non-FMLA Leave of Absence.
   (1) *Paid Leave of Absence.* A Participant shall not be entitled to revoke participation in any Benefits during a paid leave of absence except in accordance with Article 4.
   (2) *Unpaid Leave of Absence*. If a Participant takes an unpaid leave of absence other than under FMLA, the Participant shall not be entitled to continue to participate in Benefits under the Plan except to the extent provided in the Adoption Agreement or in accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave. If a Participant is permitted to continue to participate in Benefit(s) under the Plan, then he or she shall not be entitled to revoke participation in such Benefit(s) during the unpaid leave of absence except in accordance with Article 4.
   (3) *USERRA.* If a Participant is on a leave of absence in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA), the Participant shall be entitled to elect to continue participation in the Premium Conversion Account and Health FSA for the lesser of (i) 24 months, beginning on the date the Participant's absence began and (ii) the date the Participant fails to apply for or return to employment with the Employer, as determined under USERRA. Notwithstanding any provision of this Plan to the contrary, contributions, Benefits and service credits with respect to qualified military service personnel shall be provided in accordance with applicable provisions of USERRA and regulations issued thereunder.
   (4) *Applicable State Law.* The Plan Administrator shall permit a Participant to continue Benefits under the Plan as required under any applicable state law to the extent that such law is not pre-empted by federal law.

Section 3.04 TERMINATION OF PARTICIPATION

If a Participant remains an Employee but is no longer an Eligible Employee (e.g., due to a change in job classification), his or her participation in the Plan and any Benefit elections shall terminate on the date on which the Participant ceases to be an Eligible Employee, unless provided otherwise herein or in the Adoption Agreement. Should such Employee again qualify as an Eligible Employee, he or she shall be eligible to participate in the Plan as of the first day of the subsequent Plan Year, unless earlier participation is required by applicable law or permitted pursuant to Section 4.03.

Section 3.05 TERMINATION OF EMPLOYMENT

If a Participant has a Termination of Employment, his or her participation in the Plan shall be governed in accordance with the terms of the applicable Benefit as provided herein.

Section 3.06 REEMPLOYMENT

(a) Except as otherwise provided in the Adoption Agreement, the Plan Administrator shall automatically reinstate Benefit elections for Eligible Employees who are rehired by an Employer within 30 days of a Termination. If an Employee has a Termination of Employment and is subsequently reemployed by the Employer as an Eligible Employee more than 30 days following the date of Termination, the Plan Administrator may allow the Eligible Employee to elect to reinstate the Benefit election in effect at the time of Termination or to make a new election under the Plan, unless otherwise provided herein or in the Adoption Agreement.

(b) *Ineligible Employees.* An Employee who has a Termination of Employment and who is subsequently reemployed by the Employer but is not an Eligible Employee shall be eligible to participate on the date the individual becomes an Eligible Employee and, at that time, may elect to participate in the Plan in accordance with Article 4.

ARTICLE 4. BENEFITS AND PARTICIPATION

Section 4.01 BENEFIT OPTIONS

Each Eligible Employee may elect to participate in the following Benefits to the extent selected in the Adoption Agreement, pursuant to the applicable Article or Sections herein:

(a) Premium Conversion Account
(b) General Purpose Health Flexible Spending Account
(c) HSA-Compatible Health Flexible Spending Account
(d) Dependent Care Assistance Plan Account
(e) Health Savings Account Contributions
(f) Flex Credits
(e) Cash Opt-Out

If the Employer has not selected in the Adoption Agreement to provide a particular Benefit, then that Benefit shall not be available to Eligible Employees and the corresponding Article and other provisions specifically referencing that Benefit in this Plan Document shall not apply. "Nonqualified benefits" as defined in IRC Section 125(f) and/or IRS Proposed Regulation Section 1.125-1(q) are not permitted in an IRC Section 125 cafeteria plan and are not offered through this Plan.

Section 4.02 ELECTION TO PARTICIPATE

(a) *Elections to Participate.* The Plan Administrator shall prescribe such forms and may require such data from an Eligible Employee as are reasonably required and permitted under applicable law to enroll the Eligible Employee in the Plan or to effectuate any elections made pursuant to this Article 4. The Plan Administrator may adopt procedures governing the elections described in this Article 4, including, without limitation, a minimum annual and per pay-period contribution amount, a maximum contribution per pay-period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan. An Eligible Employee will be enrolled as a Participant when a fully completed and signed Enrollment Form is delivered to and accepted by the Plan Administrator.

(b) *New Employees.* An Eligible Employee may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 30 days after the date the Eligible Employee becomes an Employee. Subject to satisfying any requirements to be an Eligible Employee, the election may be effective as of the Employee's hire date; provided, however, that amounts used to pay for such election must be made from Compensation not yet currently available on the date of the election.

(c) *Newly Eligible Employees.* An Employee who becomes an Eligible Employee (for example, after satisfying any Probationary Period or other eligibility requirements of the Plan or any applicable Benefit) may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 31 days after the date the Employee becomes an Eligible Employee. The election will be effective on a prospective basis.

(d) *Continuing Eligible Employees.* An Eligible Employee may elect to enroll in the Plan or to modify or revoke his or her election during the Open Enrollment Period established by the Plan Administrator that precedes the Plan Year for which the election will be effective, except as provided in Article 9. A properly completed Enrollment Form must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period. The Eligible Employee's election(s) with respect to Benefits then will become effective on the first day of the next Plan Year.

(e) *Failure to Elect.* If an Eligible Employee does not make an election in accordance with the required enrollment procedures with respect to any or all Benefits under the Plan, the Eligible Employee will be deemed to have elected not to participate in such Benefit for the applicable Plan Year, except as otherwise provided herein or specified in the Adoption Agreement.

Section 4.03 MID-YEAR ELECTION CHANGES

An Eligible Employee's election to participate in a Benefit hereunder is irrevocable during the Plan Year, except that an Eligible Employee may change his or her election during the Plan Year no later than the end of the 31-day period beginning on the date of a Change in Status (as defined below), unless provided otherwise in the Adoption Agreement. The election change must be on account of and correspond with a Change in Status

that affects eligibility for coverage under the Plan. The following subsections are intended to incorporate the change in status rules in Treasury Regulation §1.125-4, and are to be interpreted in a manner consistent with those regulations. If a change is not permitted under a particular Benefit or its underlying plan, no election change is permitted under this Plan. For example, if the Employer's group health plan does not permit a coverage change due to a certain event, no election change may be made with respect to that event under the Premium Conversion Account Benefit of this Plan.

An Eligible Employee's requested election change will be permitted under (a) through (e) of this Section only if the election change is on account of and corresponds with the change-in-status event. The Plan Administrator shall determine, in its sole discretion and on a uniform and consistent basis, whether a requested election change is on account of and corresponds with a change-in-status event. Generally, this consistency requirement will be satisfied if the event affects eligibility for coverage under the Plan or a Benefit (for example, the event results in an increase or decrease in the number of Dependents who may benefit under the Plan).

A "Change in Status" means the following:

(a) *Legal Marital Status.* Events that change an Eligible Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation, and annulment.

(b) *Number of Dependents.* Events that change an Eligible Employee's number of Dependents, including birth, death, adoption, and placement for adoption.

(c) *Employment Status.* Any of the following events that change the employment status of the Eligible Employee, the Eligible Employee's Spouse, or the Eligible Employee'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 Eligible Employee or the Eligible Employee's Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the applicable plan, then that change constitutes a change in employment under this paragraph (c).

(d) *Dependent satisfies or ceases to satisfy eligibility requirements.* Events that cause an Eligible Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(e) *Residence.* A change in the place of residence of the Eligible Employee or the Eligible Employee's Spouse or Dependent.

(f) *Special Enrollment.* In the case of a Premium Conversion Account election under the Employer's group health plan, an Eligible Employee may revoke an election during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f) (HIPAA portability rules).

(g) *COBRA.* If the Eligible Employee or the Eligible Employee's spouse or Dependent becomes eligible for continuation coverage under an Employer's group health plan under COBRA or any similar state law, the Eligible Employee may elect to increase contributions to his or her Premium Conversion Account under the Plan in order to pay for the continuation coverage.

(h) *Court Order (does not apply to DCAP Account).* A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Medical Child Support Order) that requires accident or health coverage for an Eligible Employee's child or for a foster child who is a Dependent of the employee. The Eligible Employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the Eligible Employee's Spouse, former Spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

(i) *Entitlement to Medicare or Medicaid (applies to Premium Conversion Account only).* If an Eligible Employee or an Eligible Employee's Spouse or Dependent who is enrolled in an Employer's group health plan becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Eligible Employee may make a prospective election change to cancel or reduce coverage of that Employee, Spouse, or Dependent under the Employer-sponsored group health plan. In addition, if an Eligible Employee or an Eligible Employee's Spouse or Dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the Eligible Employee may make a prospective election to commence or increase his or her coverage or the coverage of his or her Spouse or Dependent, as applicable, under the Employer-sponsored group health plan.

(j) *Significant Cost or Coverage Changes.*

(1) *Automatic Changes.* If the cost of an Employer-sponsored Contract premium increases (or decreases) during a Period of Coverage and, under the terms of the Contract, Eligible Employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Eligible Employees' salary reduction contributions for the Plan.

(2) *Significant Cost Changes.* If the cost charged to an Eligible Employee for a Contract benefit package option significantly increases or significantly decreases during a Period of Coverage, the Plan may permit the Eligible Employee to make a corresponding change in an election under the Plan. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available. For example, if the cost of an indemnity option under a group health plan significantly increases during a Period of Coverage, Eligible Employees who are covered by the indemnity option may make a corresponding prospective increase in their payments or may instead elect to revoke their election for the indemnity option and, in lieu thereof, elect coverage under another benefit package option including an HMO option (or drop coverage under the group health plan if no other benefit package option is offered).

A cost increase or decrease refers to an increase or decrease in the amount of the salary reduction contributions under the Plan, whether that increase or decrease results from an action taken by the Eligible Employee (such as switching between full-time and part-time status) or from an action taken by an Employer (such as reducing the amount of Employer contributions for a class of Eligible Employees). This paragraph (j) applies in the case of the Dependent Care Assistance Plan Account only if the cost change is imposed by a Dependent care

provider who is not a relative of the Eligible Employee as described in Code section 152(a)(1) through (8), incorporating the rules of Code section 152(b)(1) and (2). This paragraph (j) does not apply to Health FSAs.

(k) *Significant Curtailment Without Loss of Coverage.* If an Eligible Employee or an Eligible Employee's Spouse and/or Dependent has a significant curtailment of coverage under a Contract during a Period of Coverage that is not a loss of coverage as described in paragraph (l) of this section (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under the Contract), the Eligible Employee may revoke his or her election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing similar coverage. This paragraph (k) does not apply to Health FSAs.

(l) *Significant Curtailment With Loss of Coverage.* If an Eligible Employee (or an Eligible Employee's Spouse or Dependent) has a significant curtailment that is a loss of coverage, the Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. For purposes of this paragraph (l), a loss of coverage means:

(1) a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation);

(2) a substantial decrease in the medical care providers available under the Contract (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(3) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Eligible Employee or the Eligible Employee's Spouse or Dependent is currently in a course of treatment; or

(4) any other similar fundamental loss of coverage as determined by the Plan Administrator in its sole discretion.

This paragraph (l) does not apply to Health FSAs.

(m) *Addition or Improvement of a Benefit Package Option.* If the Plan or a Contract adds a new benefit package option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a Period of Coverage, an Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved benefit package option. This paragraph (m) does not apply to Health FSAs.

(n) *Change in Coverage Under Another Employer Plan.* An Eligible Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including another plan of the Employer or of another employer) if -

(1) The other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under paragraphs (a) through (o) of this section (disregarding this paragraph (n)(1)); or

(2) This Plan permits Eligible Employees to make an election for a Plan Year that is different from the Period of Coverage under the other cafeteria plan or qualified benefits plan.

This paragraph (n) does not apply to Health FSAs.

(o) *FMLA.* A Participant may make an election change under the Plan upon an FMLA leave of absence as described in Section 3.03(a) to the extent such election change is determined by the Plan Administrator to be necessary or appropriate to ensure the Plan's compliance with applicable provisions of the FMLA. See also Treasury Regulation §1.125-3.

(p) *Loss of Coverage Under Other Group Health Coverage.* An Eligible Employee may make an election on a prospective basis to add coverage under the Plan for the Eligible Employee and/or the Eligible Employee's Spouse and/or Dependent if the Eligible Employee and/or the Eligible Employee's Spouse and/or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including a State's 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)(40)), the Indian Health Service, or a tribal organization; a State health benefits risk pool; or a Foreign government group health plan. This paragraph (p) does not apply to Health FSAs.

(q) *Revocation due to Reduction in Hours of Service (applies to Premium Conversion Account only).* A Participant may prospectively elect to cancel contribution for and payment of the Employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the Employer-sponsored group health plan and (2) the revocation of the election of coverage under the Employer-sponsored group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(r) *Enrollment in a Qualified Health Plan (applies to Premium Conversion Account only).* A Participant may prospectively elect to cancel contribution for and payment of the employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant is eligible for a special enrollment period to enroll in a "qualified health plan" through a competitive marketplace established under Section 1311 of the Patient Protection and Affordable Care Act ("Marketplace") or the (2) Employee seeks to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.

Change in Status shall also include any other event that the Plan Administrator determines, in its sole discretion and on a uniform and consistent basis, permits the revocation of an election (and, if applicable, the filing of a new election) during a Plan Year under then applicable regulations and rulings of the Internal Revenue Service. The Plan Administrator reserves the right to determine whether an Eligible Employee has experienced a Change in Status and whether the Eligible Employee's requested election is consistent with such Change in Status.

ARTICLE 5. PREMIUM CONVERSION ACCOUNT

Section 5.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Premium Conversion Accounts, an Eligible Employee may elect to have a portion of his or her Compensation applied by the Employer toward the Premium Conversion Account. The Account established under this Article 5 is intended to qualify under Code sections 79 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

If an Eligible Employee elects coverage for a Plan Year under a group health plan and/or other Employer-sponsored or individual Contract(s) listed in the Premium Conversion Account section of the Adoption Agreement, the coverages and benefits with respect to such Contract will be provided not by this Plan but by the particular Contract listed in the Adoption Agreement. The types and amounts of benefits available under each Contract, the eligibility and enrollment requirements for participating in such Contract, and the other terms and conditions of coverage and benefits under such Contract shall be as set forth from time to time in the specific documents applicable to such Contract. The eligibility and enrollment requirements, benefit descriptions and other provisions of such Contract, as relevant and in effect from time to time, are hereby incorporated by reference into this Plan.

Section 5.02 ELIGIBLE EMPLOYEES

All Employees who are eligible to participate in the applicable Employer-sponsored or individual Contract(s) shall be eligible to participate in the Premium Conversion Account, except as otherwise specified in the Adoption Agreement.

Section 5.03 ENROLLMENT

(a) *Enrollment.* The Eligible Employee may elect, in accordance with the election procedures described in Sections 4.02 and 4.03, to receive benefits and pay on a pre-tax basis through salary reduction his or her portion of the premium cost of coverage under the Employer group health plan and/or other Contract(s) that are listed in the Premium Conversion Account section of the Adoption Agreement.

(b) *Contributions.* A Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation. The amount of a Participant's contribution to the Premium Conversion Account shall be equal to the amount of the Participant's portion of the premium on the applicable Contract. Except as elected in the Adoption Agreement, if the amount of the Participant's portion of the applicable premium on the Contract increases or decreases, the Participant's contribution to the Premium Conversion Account will automatically be adjusted to reflect the increase or decrease.

(c) *Maximum Contributions*. The maximum salary reduction contribution that may be elected under the Premium Conversion Account by an Eligible Employee shall be the total premium costs to the Eligible Employee for the Plan Year of the most expensive coverage options under the Contracts listed in the Adoption Agreement that could be elected by the Eligible Employee for that Plan Year. The maximum non-elective Employer contribution shall be the balance of the total premium costs of those coverage options in excess of the Eligible Employee's salary reduction contribution.

(d) *Failure to Elect.* An Eligible Employee who elected not to participate in the Premium Conversion Account for a Plan Year will not be enrolled in the Premium Conversion Account for any subsequent Plan Year until he or she affirmatively elects to participate in the Premium Conversion Account in accordance with Article 4. An existing Participant's failure to make an election relating to the Premium Conversion Account by submitting an Enrollment Form during the Open Enrollment Period prior to any subsequent Plan Year shall constitute (i) a re-election of the same coverage or coverages, if any, under such Contract(s) as were in effect just prior to the end of the preceding Plan Year to the extent coverage remains available under the Premium Conversion Account, and (ii) an agreement to a reduction in the Participant's Compensation for the subsequent Plan Year equal to the Employee's share of the cost of such Contract coverage(s).

Section 5.04 ELIGIBLE EXPENSES

A Participant's Premium Conversion Account will be debited for amounts applied to the Employee-paid portion of the applicable Contract premiums. The Plan Administrator will not direct the Employer to pay any premium on a Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

Contributions to the Premium Conversion Account for Code section 79 coverage (group term life insurance) shall be made on an after-tax basis to the extent that the premiums relate to coverage in excess of the limit described in Code section 79(a).

Section 5.05 TERMINATION OF EMPLOYMENT

Upon a Participant's Termination of Employment, the Participant's contributions to the Premium Conversion Account will cease, except with respect to contributions for COBRA continuation coverage under the Employer-sponsored Contract, if applicable. Coverage under the applicable Contract may continue in accordance with the terms of the Contract for the remainder of the Period of Coverage with respect to which the required Contract premium has been paid.

Section 5.06 NON-TAX DEPENDENT COVERAGE AS TAXABLE BENEFIT

If selected in the Adoption Agreement, a Participant may elect group medical and/or dental plan coverage for a Non-Tax Dependent as a taxable benefit under this Plan in accordance with the provisions of this Section 5.06. If (i) the Employer selects the Premium Conversion Account Benefit with respect to the Employer's group medical and/or dental plan(s), and (ii) the Participant elects to cover a Non-Tax Dependent through the

Participant's coverage under group medical and/or dental benefit plan(s), the following rules shall apply. A Participant who elects to participate in the Premium Conversion Account Benefit may pay on a pre-tax basis through salary reduction contributions the Participant's portion of the premium cost of coverage under the Employer's group medical and/or dental plan(s) for a Non-Tax Dependent in accordance with Section 5.01, provided that the full fair market value of such health and/or dental plan coverage for any such Non-Tax Dependent shall be includible in the Participant's gross income as a taxable benefit in accordance with applicable federal income tax rules. For purposes of this Plan, the Participant electing coverage for Non-Tax Dependent(s) shall be treated as receiving, at the time that coverage is received, cash compensation equal to the full fair market value of such coverage and then as having purchased the coverage with after-tax employee contributions.

No Health FSA or DCAP Account Benefits for Non-Tax Dependents. Notwithstanding the foregoing, no medical care or dependent care expenses incurred by or with respect to a Non-Tax Dependent of a Participant shall be eligible for reimbursement as eligible expenses under Articles 6, 7, or 8.

ARTICLE 6. GENERAL PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT

Section 6.01 IN GENERAL

To the extent that the Adoption Agreement authorizes General Purpose Health Flexible Spending Accounts, an Eligible Employee may elect to participate in a General Purpose Health Flexible Spending Account in accordance with this Article 6. The Account established under this Article 6 is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 6.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the General Purpose Health Flexible Spending Account, except as otherwise specified in the Adoption Agreement. An Employee who is not eligible to participate in an Employer group medical plan is not eligible to participate in the General Purpose Health Flexible Savings Account. An Eligible Employee who has elected to participate in the HSA Contributions Benefit and/or the HSA-Compatible Health FSA Benefit is not eligible to participate in the General Purpose Health FSA Benefit under this Article 6.

Section 6.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the General Purpose Health FSA and elect to have a portion of his or her Compensation contributed to a General Purpose Health FSA in accordance with Article 4. A Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03.

(b) *Contributions.* A Participant's General Purpose Health FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a General Purpose Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 6.04 LIMITS

(a) The amount of an Eligible Employee's contribution to a Health Flexible Spending Account shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 125(i), as adjusted. The Code section 125(i) limit is reduced by the amount of Flex Credits, if any, that a Participant may elect to receive in cash as set forth in the Adoption Agreement or as a taxable benefit.

(b) Employer contributions to a Participant's Health FSA will not exceed the greater of (a) two times the amount elected in the Participant's Salary Reduction Agreement to be contributed to the Health FSA for the Plan Year, including Flex Credits the Participant elects to contribute to the Health FSA, if applicable or, (b) $500 plus the amount elected in the Participant's Salary Reduction Agreement and any Flex Credits contributed to the Health FSA. If the Plan provides for Flex Credits but does not allow the cash out of the Flex Credits, the maximum amount of Flex Credits that a Participant can elect to contribute to the Health FSA shall be treated as an Employer contribution for purposes of this Section 6.04(b).

Section 6.05 ELIGIBLE EXPENSES

(a) *Debits from the Health FSA.* A Participant's Health FSA will be debited for expenses described in this Section 6.05. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the Health FSA (plus any Employer contributions and carryover amounts), less any reimbursements already disbursed from the General Purpose Health FSA, shall be available to the Participant at any time during the Plan Year without regard to the balance in the General Purpose Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.

(b) *Eligible Expenses.* Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her General Purpose Health FSA for expenses that are: (i) incurred in the Plan Year (or Grace Period, if applicable) by the Participant (or his or her Spouse or Dependent) for medical care (as defined in Code section 213(d)), (ii) incurred while he or she is a Participant in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses are not covered, paid or reimbursed from any other source. Reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses under Code section 105(b) only if such medicine or drug is prescribed (determined without regard to whether such drug is available without a prescription) or is insulin, as provided by IRS Notice 2010-59, as amended.

Section 6.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The FSA Administrator shall reimburse a Participant from his/her General Purpose Health FSA for eligible expenses incurred during the Period of Coverage. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's General Purpose Health FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a Grace Period. Any claims for reimbursement paid during a Grace Period for eligible expenses incurred during the Grace Period shall be applied first against any unused Health FSA Benefits remaining for the Plan Year to which the Grace Period relates, and then against Health FSA Benefits, if any, elected by the Eligible Employee for the subsequent Plan Year. No claims incurred during a Grace Period shall be reimbursed from a General Purpose Health FSA if the Plan permits carryover of General Purpose Health FSA balances under Section 6.07(b).

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her General Purpose Health FSA no later than the last day of the Run-out Period for the relevant Period of Coverage. The claim must be made in the manner required by the FSA Administrator.

(c) *Payment of Claims.* To the extent that the FSA Administrator approves the claim, the FSA Administrator shall: (i) reimburse the Participant or, (ii) limited to Debit Card use only, pay the service provider directly for any amounts payable from General Purpose Health FSA. The FSA Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The FSA Administrator may provide that payments/reimbursements from the General Purpose Health FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Period of Coverage (including Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(d) *Coordination with HRA.* A Participant who is also eligible to participate in an HRA sponsored by the Employer shall not be entitled to payment/reimbursement under the General Purpose Health FSA for expenses that are reimbursable under both the General Purpose Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the General Purpose Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the General Purpose Health FSA have been paid.

(e) *Automatic Payment.* If the Adoption Agreement so provides, a Participant who elects to receive coverage under a Contract that is offered in conjunction with an Employer group health plan may elect that any eligible expenses that are not covered under the applicable Contract, such as co-payments, co-insurance or deductibles, be automatically paid through his or her General Purpose Health FSA.

(f) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of Debit Cards for payment of eligible General Purpose Health FSA expenses as provided in Section 16.04.

Section 6.07 FORFEITURES

(a) *Forfeitures.* Any balance remaining in a Participant's General Purpose Health FSA at the end of any Plan Year that exceeds the carryover amount limit in subsection (b) below, if applicable (or after the Grace Period described in Section 6.06(a), if applicable), shall be forfeited and shall not be carried over to a subsequent Plan Year and shall not be available to the Participant in any other form or manner.

(b) *Carryovers.* Notwithstanding subsection (a), if and to the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Plan Year up to $500 of any amount remaining unused as of the end of the Plan Year in a Participant's General Purpose Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the General Purpose Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible expenses incurred during the Plan Year to which it is carried over. Any unused amount remaining in the General Purpose Health FSA in excess of $500 (or a lower amount specified in the Adoption Agreement) will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the carryover in the following Plan Year, provided that any such procedure is non-discriminatory and permitted by applicable IRS rules.

(c) *Use of General Purpose Health FSA Experience Gains*. General Purpose Health FSA Experience Gains (if any) with respect to a Plan Year may be retained by the Employer, or if not retained by the Employer shall be used only as permitted by applicable IRS regulations.

Section 6.08 RESERVED

Section 6.09 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's Health FSA shall cease upon Termination of Employment. Any balance remaining in a Participant's Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the Run-out Period for the applicable Period of Coverage.

Section 6.10 QUALIFIED RESERVIST DISTRIBUTIONS

(a) If the Adoption Agreement provides for Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his General Purpose Health FSA specified in the Adoption Agreement. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the Spouse of the Participant.

(b) A Participant may submit General Purpose Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.

(c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any applicable superseding guidance.

Section 6.11 SEPARATE PLAN

Although described within this document, the General Purpose Health FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The General Purpose Health FSA is also a separate plan for purposes of HIPAA and COBRA.

ARTICLE 7. HSA-COMPATIBLE HEALTH FLEXIBLE SPENDING ACCOUNT

Section 7.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Limited Purpose Health Flexible Spending Accounts ("HSA-Compatible Health FSAs"), an Eligible Employee may elect to have a portion of his or her Compensation contributed to an HSA-Compatible Health FSA. The Account established under this Article 7 is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 7.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the HSA-Compatible Health FSA Benefit except as specified in the Adoption Agreement. An Employee who is not eligible to participate in an Employer group medical plan is not eligible to participate in the HSA-Compatible Health FSA. An Eligible Employee who has elected to participate in the General Purpose Health FSA Benefit under Article 6 is not eligible to elect an HSA-Compatible Health FSA Benefit under this Article 7 for the same Plan Year unless otherwise permitted under Section 4.03 or other applicable IRS rules.

Section 7.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in an HSA-Compatible Health FSA in accordance with Article 4. An HSA-Compatible Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03.

(b) *Contributions.* A Participant's HSA-Compatible Health FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an HSA-Compatible Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 7.04 LIMITS

(a) The amount of an Eligible Employee's contribution to an HSA-Compatible Health FSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 125(i), as adjusted. The Code section 125(i) limit is reduced by the amount of Flex Credits, if any, that a Participant may elect to receive in cash as set forth in the Adoption Agreement or as a taxable benefit.

(b) Employer contributions to a Participant's HSA-Compatible Health FSA will not exceed the greater of (a) two times the amount elected in the Participant's Salary Reduction Agreement to be contributed to the HSA-Compatible Health FSA for the Plan Year, including Flex Credits the Participant elects to contribute to the HSA-Compatible Health FSA, if applicable or, (b) $500 plus the amount elected in the Participant's Salary Reduction Agreement and any Flex Credits contributed to the HSA-Compatible Health FSA. If the Plan provides for Flex Credits but does not allow the cash out of the Flex Credits, the maximum amount of Flex Credits that a Participant can elect to contribute to the HSA-Compatible Health FSA shall be treated as an Employer contribution for purposes of this Section 7.04(b).

Section 7.05 ELIGIBLE EXPENSES

(a) *Debits from the HSA-Compatible Health FSA.* A Participant's HSA-Compatible Health FSA will be debited for expenses described in this Section 7.05. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the HSA-Compatible Health FSA (plus any Employer contributions and carryover amounts), less any reimbursements already disbursed for

the Plan, shall be available to the Participant at any time during the Plan Year without regard to the balance in the HSA-Compatible Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.

(b) *Eligible Expenses*. Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her HSA-Compatible Health FSA for expenses that are: (i) incurred in the Plan Year (or Grace Period, if applicable) by the Participant (or his/her Spouse or Dependent), (ii) incurred while he/she is a Participant in the Plan, (iii) excludable under Code section 105(b), and (iv) incurred for dental or vision care; provided that such expenses are not covered, paid or reimbursed from any other source. For purposes of (iii) above, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses under Code section 105(b) only if such medicine or drug is prescribed (determined without regard to whether such drug is available without a prescription), as provided by IRS Notice 2010-59, as amended.

Section 7.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The FSA Administrator shall reimburse a Participant from his/her HSA-Compatible Health FSA for eligible expenses incurred during the Period of Coverage or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in an HSA-Compatible Health FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a Grace Period. Any claims for reimbursement paid during a Grace Period for eligible expenses incurred during the Grace Period shall be applied first against any unused HSA-Compatible Health FSA Benefits remaining for the Plan Year to which the Grace Period relates, and then against HSA-Compatible Health FSA Benefits, if any, elected by the Eligible Employee for the subsequent Plan Year. No claims incurred during a Grace Period shall be reimbursed from an HSA-Compatible Health FSA if the Plan permits carryover of HSA-Compatible Health FSA balances under Section 7.07(b).

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her HSA-Compatible Health FSA no later than the last day of the Run-out Period for the relevant Period of Coverage. The claim must be made in the manner required by the FSA Administrator.

(c) *Substantiation of Claims.* A Participant's claims for reimbursement from a Limited Purpose Health FSA must include information from an independent third-party that the medical expenses to be reimbursed are for vision care or dental care.

(d) *Payment of Claims.* To the extent that the FSA Administrator approves the claim, the FSA Administrator shall: (i) reimburse the Participant, or (ii) limited to Debit Card use only, pay the service provider directly for any amounts payable from the HSA-Compatible Health FSA. The FSA Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The FSA Administrator may provide that payments/reimbursements from the HSA-Compatible Health FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Period of Coverage (including Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(e) *Coordination with HRA.* A Participant who is also eligible to participate in an HRA sponsored by the Employer shall not be entitled to payment/reimbursement under the HSA-Compatible Health FSA for expenses that are reimbursable under both the HSA-Compatible Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the HSA-Compatible Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the HSA-Compatible Health FSA have been paid.

(f) *Automatic Payment.* If the Adoption Agreement so provides, a Participant who elects to receive coverage under a Contract that is offered in conjunction with an Employer group health plan may elect that any eligible expenses that are not covered under the applicable Contract, such as co-payments, co-insurance or deductibles, be automatically paid through his or her HSA-Compatible Health FSA.

(g) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of Debit Cards for payment of eligible HSA-Compatible Health FSA expenses as provided in Section 16.04.

Section 7.07 FORFEITURES

(a) *Forfeitures.* Any balance remaining in a Participant's HSA-Compatible Health FSA at the end of any Plan Year that exceeds the carryover amount limit in subsection (b) below, if applicable, (or after the Grace Period described in Section 7.06(a), if applicable) shall be forfeited and shall not be carried over to a subsequent Plan Year and shall not be available to the Participant in any other form or manner.

(b) *Carryovers.* Notwithstanding subsection (a) if and to the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Plan Year up to $500 of any amount remaining unused as of the end of the Plan Year in a Participant's HSA-Compatible Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the HSA-Compatible Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible expenses incurred during the entire Plan Year to which it is carried over. Any unused amount remaining in the HSA-Compatible Health FSA in excess of $500 (or a lower amount specified in the Adoption Agreement) will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, requiring a Participant to use the carryover in the following Plan Year, provided that any such procedure is non-discriminatory and permitted by applicable IRS rules.

(c) *Use of HSA-Compatible Health FSA Experience Gains*. HSA-Compatible Health FSA Experience Gains (if any) with respect to a Plan Year may be retained by the Employer, or if not retained by the Employer shall be used only as permitted by applicable IRS regulations.

Section 7.08 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's HSA-Compatible Health FSA shall cease upon Termination of

Employment. Any balance remaining in a Participant's HSA-Compatible Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the Run-out Period for the applicable Period of Coverage.

Section 7.09 QUALIFIED RESERVIST DISTRIBUTIONS

(a) If the Adoption Agreement provides for Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his HSA-Compatible Health FSA specified in the Adoption Agreement. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the Spouse of the Participant.
(b) A Participant may submit HSA-Compatible Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.
(c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any applicable superseding guidance.

Section 7.10 SEPARATE PLAN

Although described within this document, the HSA-Compatible Health FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The Health FSA is also a separate plan for purposes of HIPAA and COBRA.

ARTICLE 8. DEPENDENT CARE ASSISTANCE PLAN ACCOUNT

Section 8.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Dependent Care Assistance Plan Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to a DCAP Account. The Account established under this Article 8 is intended to qualify as a dependent care assistance program under Code section 129 and shall be interpreted in a manner consistent with such Code section.

Section 8.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the Dependent Care Assistance Plan Account, except as specified in the Adoption Agreement.

Section 8.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the DCAP Account in accordance with Article 4. A DCAP Account election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03.
(b) *Contributions.* A Participant's DCAP Account will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.
(c) *Failure to Elect.* An Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a DCAP Account for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 8.04 LIMITS

The amount of all contributions to a Participant's DCAP Account shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 129(a)(2), as adjusted.

Section 8.05 ELIGIBLE EXPENSES

(a) *Debits from the DCAP Account.* A Participant's DCAP Account will be debited for expenses described in this Section 8.05. However, such expenses will not be reimbursed to the extent the reimbursement would exceed the balance of the Participant's DCAP Account.
(b) *Eligible Expenses.*
    (1) Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her DCAP Account for Dependent Care Expenses that are: (i) incurred in the Plan Year, (ii) are incurred while the Participant participates in the Plan, and (iii) qualify as eligible Dependent Care Expenses (as defined in Section 8.05(b)(2) below), provided that such expenses are not covered, paid or reimbursed from any other source and the Participant does not claim a tax credit for such expenses. A Dependent Care Expense is "incurred" at the time the dependent care or service giving rise to the expense is actually furnished, and not when the Participant (or Spouse or Dependent) is billed or charged for, or pays for the dependent care services.
    (2) "Dependent Care Expenses" are expenses incurred for the care of a Qualifying Individual, as defined in Code section 21(b)(1) and generally includes either: (i) a Dependent who is under age 13, or (ii) the Participant's Spouse or Dependent who lives with the Participant for more than one-half of the year and is physically or mentally incapable of caring for himself/herself. However, these

expenses are Dependent Care Expenses only if they allow the Participant and his/her Spouse, if any, to be gainfully employed or in search of gainful employment, and otherwise qualify as employment-related expenses under Code section 21(b)(2). Dependent Care Expenses include expenses for household services and expenses for the care of a Qualifying Individual. Such term shall not include kindergarten and grade school expenses, or any amount paid for services outside the Participant's household at a camp where the Qualifying Individual stays overnight. Expenses described in this subsection (2) that are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's Spouse or Dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least eight hours per day in the Participant's household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals. In general, expenses for a period during which the Participant is absent from work (whether paid or unpaid), other than short, temporary absences, are not employment-related expenses. See Treas. Reg. §1.121-1(c). Qualifying expenses do not include transportation, clothing, entertainment, or food costs unless such items are incidental and cannot be separated from another qualifying expense.

Section 8.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The FSA Administrator shall reimburse a Participant from his/her DCAP Account for eligible expenses incurred during the Period of Coverage or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's DCAP Account at the end of a Plan Year may be used to reimburse eligible expenses that are incurred during a Grace Period. If the Adoption Agreement so provides, an individual who ceases to be a Participant in the Plan (due to Termination or any other reason) may spend down his or her unused DCAP Account balance, and such individuals may be reimbursed for eligible expenses incurred through the end of the Plan Year in which the Termination of Participation occurs (or end of the Grace Period if applicable) to the extent the claims do not exceed the balance of the DCAP Account.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her DCAP Account no later than the last day of the Run-out Period for the relevant Period of Coverage. The claim must be made in the manner required by the FSA Administrator.

(c) *Payment of Claims.* To the extent that the FSA Administrator approves the claim, the FSA Administrator shall: (i) reimburse the Participant, or (ii) limited to Debit Card use only, pay the service provider directly for any amounts payable from DCAP Account. The FSA Administrator may provide that payments/reimbursements from the DCAP Account of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Period of Coverage (including Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(d) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of Debit Cards for payment of eligible DCAP Account expenses as provided in Section 16.04.

Section 8.07 FORFEITURES

(a) *Forfeitures*. Any balance remaining in a Participant's DCAP Account at the end of any Plan Year (or after the Grace Period described in Section 8.06(a), if applicable) shall be forfeited and shall not be carried over to a subsequent Plan Year and shall not be available to the Participant in any other form or manner.

(b) *Use of DCAP Account Experience Gains*. DCAP Account Experience Gains (if any) with respect to a Plan Year may be retained by the Employer, or if not retained by the Employer shall be used only as permitted by applicable IRS regulations.

Section 8.08 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's DCAP Account shall cease upon Termination of Employment. Any balance remaining in a Participant's DCAP Account on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the Run-out Period for the applicable Period of Coverage.

Section 8.09 SEPARATE PLAN

Although described within this document, the DCAP Account is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 129. The DCAP Account is also a separate plan for purposes of HIPAA and COBRA, which laws do not apply to DCAP Accounts.

ARTICLE 9. HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTIONS

Section 9.01 IN GENERAL

To the extent that the Adoption Agreement authorizes contributions to Health Savings Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to a Health Savings Account. The Account referred to under this Article 9 is intended to qualify as a health savings account under Code section 223 and shall be interpreted in a manner consistent with such Code section.

The maximum amount of HSA contributions through salary reduction that an Eligible Employee may elect to make for any Period of Coverage shall be set forth in the Adoption Agreement or applicable enrollment materials for each Plan Year. The Employer may set a different maximum salary reduction HSA contribution amount for any Plan Year prior to the beginning of the applicable Plan Year.

Section 9.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 who, as of the first day of the month, are enrolled in a high deductible health plan ("HDHP") as defined in Code section 223(c)(2) are eligible to participate in the Health Savings Account Contributions Benefit for the month, except as specified in the Adoption Agreement. An Eligible Employee who has elected to participate in a General Purpose Health FSA is not eligible to participate in the HSA Contributions Benefit under this Article 9. A Participant who has elected the General Purpose Health FSA Benefit that is in effect on the last day of a Plan Year cannot elect the HSA Contributions Benefit under this Article 9 for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's General Purpose Health FSA is $0 as of the last day of such Plan Year. An Eligible Employee who is not enrolled in a high deductible health plan as defined in Code section 223(c)(2) is not eligible to elect the HSA Contributions Benefit.

Section 9.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the HSA Contributions Benefit and elect to have a portion of his/her Compensation contributed to an HSA in accordance with Article 4. An HSA Contributions election may be modified as determined by the Plan Administrator, but no less frequently than monthly, provided, however, that any modification of an election during the Plan Year shall apply on a prospective basis only. A Participant who becomes ineligible to make HSA contributions may prospectively revoke his or her HSA contribution election. For purposes of this Section, an Eligible Employee's decision to change, revoke or make a new salary reduction election shall be considered prospective if the election is made and effective before the salary or wage payments to which it relates become currently available to the Employee.

(b) *Contributions.* Amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement and applicable Employer rules with respect to such HSA contributions will be sent by the Employer directly to the Participant's HSA for deposit.

(c) *Failure to Elect.* An Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an HSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year, until an election is made in accordance with (a) above.

Section 9.04 LIMITS

The amount of contributions to a Participant's HSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 223(b), as adjusted.

Section 9.05 ADMINISTRATION

The HSA Benefit is not an employer-sponsored employee benefit plan - it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the Employer does not establish or maintain the HSA. The Plan Administrator will maintain records to keep track of HSA contributions by the Employer and by the Participant, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

Section 9.06 TERMINATION OF EMPLOYMENT

Except as expressly provided herein, all contributions to a Participant's HSA will terminate upon a Termination of Employment. The Participant will continue to be eligible to receive a distribution from his or her HSA in accordance with the terms of the documents governing the HSA.

ARTICLE 10 - RESERVED

ARTICLE 11. OTHER BENEFITS

Section 11.01 NON-ELECTIVE EMPLOYER CONTRIBUTIONS AND FLEX CREDITS

To the extent authorized in the Adoption Agreement, an Employer may make non-elective Employer contributions and/or Flex Credits available through the Plan. The Employer may, but is not required to, allocate non-elective Employer contributions to the Health FSAs or DCAP Accounts of Participants, and also may provide Employer contributions in the form of Flex Credits that Participants may allocate among one or more Benefits under the Plan. The Employer also may make non-elective Employer contributions to the HSAs of Participants who are then participating in an HDHP. The amount, if any, of such non-elective Employer contributions or Flex Credits available for any Plan Year, and the specific terms thereof, shall be set forth in the Adoption Agreement, on the Enrollment Form, or in such other Plan materials provided by the Employer to Eligible Employees for the Plan Year. Such non-elective Employer contributions or Flex Credits, if any, shall be made available to Eligible Employees or classes of Eligible Employees on a reasonably uniform and nondiscriminatory basis, and in the case of a Health FSA shall be subject to the limitations set forth in this Plan and 45 CFR 146.145(c)(3)(v) so that each Health FSA under the Plan qualifies as an "excepted benefit" for purposes of such regulation.

For a Period of Coverage which is less than 12 months, the amount of any non-elective Employer contributions or Flex Credits provided by the Employer shall be prorated by multiplying the annual Plan Year amount by a fraction with a numerator equal to the number of pay periods in such Period of Coverage and a denominator equal to the total number of pay periods in a Plan Year. Non-elective Employer contributions and Flex Credits as determined above shall be earned in equal pro-rata amounts on the last day of each payroll period throughout the Period of Coverage. The preceding sentences in this paragraph shall be subject to and modified by any applicable provisions to the contrary set forth in the Adoption Agreement, on the Enrollment Form, or in such other Plan materials provided by the Employer to Eligible Employees for the Plan Year.

Section 11.02 CASH OPT-OUT BENEFIT

If made available by the Employer in the Adoption Agreement, an Eligible Employee may elect, for any Plan Year, to receive a cash payment in lieu of receiving coverage under the Employer's group health plan and/or other benefit plan(s) referenced in the Adoption Agreement. The amount(s) of this Cash Opt-Out Benefit for any Plan Year shall be established by the Employer prior to the beginning of the Plan Year, and such amount(s) shall be set forth on the Enrollment Form for the relevant Plan Year or in such other plan materials provided by the Employer to Eligible Employees. The Eligible Employee shall elect the Cash Opt-Out Benefit by completing the relevant section of the Enrollment Form prior to the beginning of the Plan Year. Unless otherwise provided in the Adoption Agreement or other plan materials, for a Period of Coverage that is less than 12 months, the amount of the Cash Opt-Out Benefit shall be pro-rated by multiplying the annual Plan Year amount by a fraction with a numerator equal to the number of pay periods in such Period of Coverage and a denominator equal to the total number of pay periods in a Plan Year.

Section 11.03 CASH OUT OF FLEX CREDITS

(a) *In General.* To the extent provided in the Adoption Agreement, a Participant may elect to receive a cash distribution of Flex Credits from the Plan.
(b) *Eligible Employees.* To the extent provided in the Adoption Agreement, the Employees identified in Article 3 are eligible to receive a cash distribution from the Plan under this Section 11.03.

ARTICLE 12 - RESERVED

ARTICLE 13. NONDISCRIMINATION

Section 13.01 NONDISCRIMINATION REQUIREMENTS

This Plan is intended not to violate any nondiscrimination requirements imposed by Code Section 125 and other applicable Internal Revenue Code provisions and should be interpreted accordingly. The following nondiscrimination requirements shall apply:

(a) *Cafeteria Plan.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate.
(b) *Group Term Life.* The Plan may not discriminate in favor of Key Employees as to benefits provided or eligibility to participate with respect to any group term life insurance offered pursuant to Section 4.01.
(c) *Health Flexible Spending Account.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate with respect to the Health FSA.
(d) *Dependent Care Assistance Plan Accounts.* The Plan may not discriminate in favor of Highly Compensated Employees as to benefits provided or eligibility to participate with respect to DCAP Accounts.

Section 13.02 ADJUSTMENTS

If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator or the FSA Administrator at the Plan Administrator's direction may modify any election or take such other actions necessary in the Plan Administrator's judgment in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Section 13.02 shall be carried out in a uniform and non-discriminatory manner.

ARTICLE 14. PLAN ADMINISTRATION

Section 14.01 PLAN ADMINISTRATOR

(a) *Designation.* The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator.
(b) *Authority and Responsibility of the Plan Administrator.* The administration of the Plan shall be the responsibility of the Plan Administrator. The Plan Administrator has the discretionary power and authority to interpret the Plan and to determine all questions that arise under it, including, without limitation, questions of eligibility and amounts of Benefits due under the Plan. All determinations, interpretations, and decisions of the Plan Administrator shall be applied uniformly and consistently in a nondiscriminatory manner and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.
(c) *Procedures.* The Plan Administrator (and the FSA Administrator as applicable) may establish such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive

as to all parties.

(d) *Allocation of Duties and Responsibilities.* The Plan Administrator may designate other persons to carry out any of the Plan Administrator's duties and responsibilities under the Plan, including one or more officers or employees of the Employer, or individuals or entities independent of the Employer (such as the FSA Administrator).

Section 14.02 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Plan Sponsor shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegates) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan.

ARTICLE 15. AMENDMENT AND TERMINATION

Section 15.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor or its authorized representative.

Section 15.02 TERMINATION

(a) The Plan Sponsor reserves the right to terminate the Plan or any Benefit at any time for any reason.

(b) A participating Employer may terminate its participation in this Plan upon (i) written notice to the Plan Sponsor of its intent to terminate participation in the Plan, (ii) the closing of a merger in which the participating Employer is not the surviving entity and the surviving entity is not an Affiliate of the Plan Sponsor, or (iii) the sale of all or substantially all of the participating Employer's assets to an entity that is not an Affiliate of the Plan Sponsor.

ARTICLE 16. CLAIMS PROCEDURES

Section 16.01 CONTRACT BENEFIT AND HSA CLAIMS

(a) *Benefits Provided by Contracts.* Claims and reimbursement for benefits provided under any Contract shall be administered in accordance with the claims procedures for the applicable Contract, as set forth in the Contract's plan documents, summary plan description, and/or similar documentation.

(b) *HSA Claims.* Claims relating to the HSA shall be administered by the HSA trustee/custodian in accordance with the HSA trust or custodial document between the Participant and such trustee/custodian.

Section 16.02 CLAIMS PROCEDURES FOR PLAN ACCOUNTS (OTHER THAN CONTRACT BENEFITS AND HSA)

(a) *Claims.* A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.

(b) *Health FSA and DCAP Account Claims for Reimbursement*. A Participant with a Health FSA or DCAP Account may apply for reimbursement of eligible expenses incurred during the relevant Period of Coverage by submitting a claim in writing to the FSA Administrator or by such other method acceptable to the FSA Administrator. In addition to the provisions of this sub-section (b), a Participant may use a Debit Card for reimbursement of eligible expenses in accordance with Section 16.04 below. All claims for reimbursement should be submitted to the FSA Administrator as soon as reasonably possible but no later than the last day of the Run-out Period for the relevant Period of Coverage. A claim for reimbursement may be made before or after the Participant has paid the eligible expense but not before the expense has been incurred.

Any such claim shall include all information and evidence that the FSA Administrator deems necessary to properly evaluate the merit of and to make any necessary determination. A claim for reimbursement shall be in such form(s) as may be prescribed by the FSA Administrator and generally shall set forth:

(i) the amount, date and nature of each expense for which reimbursement is being sought;

(ii) the name of the provider of the service or item that gave rise to the expense;

(iii) the name of the person for whom the expense was incurred and, if not the Participant, the relationship of such person to the Participant; and

(iv) a statement from the Participant that the expense (or portion thereof) for which reimbursement is being sought has not been reimbursed and is not eligible for reimbursement under any other group health plan, insurance or other source.

The claim for reimbursement shall be accompanied by a bill, paid receipt, explanation of benefits, or other written statement from an independent third party stating that the expense has been incurred and the amount of such expense. The FSA Administrator may request any additional information necessary to evaluate the claim.

A claim form and supporting documentation or information should be mailed, emailed or faxed to the FSA Administrator at the following address:

HealthTrust, Inc.
Attn: Benefit Advantage-Confidential
PO Box 617
Concord, NH 03302-0617
Fax: (603) 415-3099
Tel: (603) 226-2861
Email: benefitadvantage@healthtrustnh.org

The FSA Administrator will review properly submitted claims promptly upon receipt and will make a decision on the claim in accordance with relevant Plan provisions and the FSA Administrator's standard claims processing procedures. The FSA Administrator shall notify the Participant of any claim denial within a reasonable period of time, ordinarily within 30 days after receipt of the claim, unless the FSA Administrator determines additional time is required to make a determination.

(c) *Denial of Claims*. If a claim for reimbursement or benefits is denied in whole or in part, the Participant will receive a written notice from the FSA Administrator that includes:

(i) The reason or reasons for the denial;

(ii) A description of any additional information or material needed to support the claim and an explanation of why the additional information or material is necessary; and

(iii) An explanation of the procedures for a Participant to appeal the denied claim.

(d) *Review Procedures; Appeals to Plan Administrator*. A Participant may request in writing a review of a denial of a claim within sixty (60) days after the Participant receives the written notice of denial. The Participant's appeal request should include the reasons that he or she feels the claim should not have been denied and any additional facts and/or documents that the Participant believes supports the claim. The Participant may review (upon request) documents and other non-privileged information that are relevant to his or her appeal. The appeal letter and supporting information or documentation should be mailed to the address set forth in Section 16.02(b) above.

Properly submitted written appeals will be reviewed promptly by the Plan Administrator. A written notice of decision on appeal will be sent to the Participant within sixty (60) days after the Plan Administrator receives the appeal letter. However, if special circumstances require a delay and the Participant is so notified, the review may take up to 120 days. The written notice will state the reasons for the Plan Administrator's decision and will refer the Participant to relevant Plan provisions and/or other documentation or information on which any adverse decision is based. The decision of the Plan Administrator on appeal shall be final, conclusive and binding.

(e) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Unless otherwise prohibited under the Plan or pursuant to applicable law, before a suit can be filed in court, claimants must exhaust the Plan's claim procedures. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Section 16.03 RECOVERY OF MISTAKEN PAYMENTS

If any reimbursement or other payment made under the Health FSA or DCAP Account Benefits of the Plan is subsequently found to have been made in error (for example, payment to an ineligible person, reimbursement of an ineligible expense, lack of required substantiation, improper use of a Debit Card, etc. – collectively, "mistaken payments"), the Plan shall be entitled to recover the amount of such mistaken payments in accordance with the procedures set forth in this Section 16.03. The FSA Administrator and the Employer shall pursue recovery of mistaken payments utilizing one or more of the following correction methods:

(i) Require the Participant or other person receiving the mistaken payment to reimburse the Plan for the amount of the mistaken payment;

(ii) If the FSA Administrator and the Employer are unable to obtain repayment per (i) above, deny the Participant reimbursement of subsequently submitted claims incurred during the same Period of Coverage until the amount of the mistaken payment is fully recovered by the Plan;

(iii) Withhold or offset the amount of the mistaken payment from the Participant's pay or compensation; or

(iv) Take such other action that the FSA Administrator and Employer reasonably deem necessary to ensure recovery of mistaken payments and that such mistaken payments do not recur (for example, deny access to the use of a Debit Card until the mistaken payment is repaid in full or revoke the card entirely).

If none of the above correction methods are successful in recovering a mistaken payment, the Employer, consistent with its business practice, shall treat the amount owed by the Employee as it would any other business debt. To the extent the Employer forgives the debt after requesting payment consistent with collection procedures for other business debt, the Employer shall report the amount of the mistaken payment to the Employee and IRS as taxable wages on Form W-2 in the taxable year of the Employee in which the debt is forgiven. Any of the above correction methods shall be pursued only in accordance with and to the extent permitted by applicable law.

Section 16.04 DEBIT CARDS

The FSA Administrator may make Debit Cards available to Participants as a means of paying for Health FSA and DCAP Account expenses and receiving reimbursement from their Accounts. A Participant who elects to use the Debit Card option may be charged annual and/or other administrative fees for use of the card. Debit Cards may be used only for reimbursement of Health FSA and DCAP Account expenses incurred during the relevant Period of Coverage, exclusive of any Grace Period.

A Participant (and Spouse or Dependent) utilizing the Debit Card shall be required to provide paper substantiation to the FSA Administrator of all Health FSA and DCAP Account expenses charged to the Debit Card, unless otherwise permitted by the FSA Administrator in accordance with applicable IRS rules. The paper substantiation shall be in the form of a bill, paid receipt, explanation of benefits, or other written statement from an independent third party stating that the expense has been incurred and the amount of such expense, and shall include any additional documentation or information that the FSA Administrator may require. Any charges to a Debit Card shall be treated as conditional reimbursement to the Participant pending receipt and approval of proper substantiation of the charge by the FSA Administrator.

Use of the Debit Card for payment of other than Health FSA and DCAP Account expenses may subject the Participant to permanent revocation of the card, and the Employer and Participant will be responsible for repayment of any such ineligible expenses reimbursed by the Participant's Health FSA or DCAP Account. See Section 16.03 "Recovery of Mistaken Payments." The Debit Card will be cancelled automatically upon the Participant's termination of employment or ineligibility for Health FSA and DCAP Account Benefits. The Participant will be charged a fee to replace and/or obtain additional Debit Cards.

Notwithstanding any provision of this Section to the contrary, Debit Cards may be used for reimbursement of Health FSA and DCAP Account expenses (including, without limitation, expenses for qualifying over-the-counter products) only if and to the extent permitted by applicable IRS rules as in effect at the time the Health FSA and/or DCAP Account expense is incurred.

ARTICLE 17. MISCELLANEOUS

Section 17.01 NONALIENATION OF BENEFITS

No Participant or beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he or she may expect to receive, contingently or otherwise, under the Plan.

Section 17.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and any Employee or Participant, or as a right of any Employee or Participant to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

Section 17.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made solely out of the general assets of the Employer.
(b) The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.
(c) No person shall have any rights to, or interest in, any Benefit or Account other than as expressly authorized in the Plan.

Section 17.04 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a Medical Child Support Order, the Plan Administrator shall comply with any applicable law or procedures governing Medical Child Support Orders.

Section 17.05 GOVERNING LAW

The Plan shall be construed in accordance with and governed by the laws of the State of New Hampshire, to the extent not preempted or superseded by applicable Federal law.

Section 17.06 TAX EFFECT

The Employer and the FSA Administrator do not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. The Participant remains solely responsible for determining whether each payment under the Plan is excludable from his or her gross income for tax purposes, and to notify the Employer if the Participant has reason to believe that such payment is not so excludable.

Section 17.07 SEVERABILITY OF PROVISIONS

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

Section 17.08 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 17.09 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

Section 17.10 TRANSFERS

Except as explicitly set forth herein, amounts may not be transferred between Accounts.

Section 17.11 COBRA

If the Plan or Benefit is subject to COBRA (or other applicable continuation law) or the Plan Administrator determines that the Plan or Benefit is subject to COBRA (or other applicable continuation law), a Participant shall be entitled to continuation coverage as prescribed in COBRA or such applicable law.

Section 17.12 CONFLICTS

In the event of a conflict between the terms of this Plan and the terms of a Contract, the terms of the Contract (or the benefit plan under which it is established) shall control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for coverage, the dates of their eligibility, the conditions that must be satisfied to become covered, if any, the benefits Participants are entitled to receive and the circumstances under which coverage terminates.

Section 17.13 DEATH

If a Participant dies, the Participant’s estate or beneficiaries may submit claims for expenses or benefits for the portion of the Period of Coverage preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. Unless prohibited by applicable law, the FSA Administrator may pay any amount due hereunder to such designated beneficiary, or if no such beneficiary is designated, to the Participant's Spouse, one or more of his or her Dependents or a representative of the Participant's estate. Such payment shall fully discharge the FSA Administrator and the Employer from further liability on account thereof.

Section 17.14 INFORMATION TO BE FURNISHED

Eligible Employees shall provide the Employer and the FSA Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of this Plan.

Section 17.15 NON-ERISA GOVERNMENTAL PLAN

This Plan, and any Benefit component that qualifies as a separate Plan, is a governmental plan established and maintained by the Employer, and as such is exempt from the provisions of ERISA.

ARTICLE 18. HIPAA PRIVACY AND SECURITY COMPLIANCE

This Article 18 shall only apply in the event that the Health FSA(s) under the Plan constitutes a group health plan as defined in 45 CFR section 160.103 or if the Plan Administrator determines that the Plan or a component Benefit is subject to the HIPAA privacy and security rules. The Plan will comply with HIPAA as set forth below.

Section 18.01 HIPAA COMPLIANCE

HIPAA requires that health plans protect the confidentiality and privacy of individually identifiable health information known as Protected Health Information ("PHI"). The Plan (at least to the extent of the Health FSA component(s)) is a "covered entity" for purposes of HIPAA and shall conduct its activities in compliance with HIPAA. This Article 18 sets forth the Plan's policy ("Policy") regarding the use and disclosure of PHI. All capitalized terms used in this Article 18 shall have the same meaning as in HIPAA or as defined in Article 2, unless otherwise indicated.

Section 18.02 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The Plan and the Employer (as Plan Sponsor and Plan Administrator, as applicable) will use and disclose PHI only to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, it is expected that the Plan and the Employer will only utilize and disclose PHI of covered Individuals for purposes of the administration of the Health FSA component(s) of the Plan. With respect to PHI that it creates, receives, maintains or transmits on behalf of the Plan, the Employer agrees that it will:

- Not use or further disclose PHI other than as permitted or required by the Plan Documents, this Policy or by law;
- Ensure that any agents to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual with respect to whom such PHI relates;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual with respect to whom the PHI relates;
- Report to the Plan any PHI use or disclosure of which it becomes aware that is inconsistent with the uses or disclosures provided for in this Policy and by HIPAA;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment by the individual with respect to whom the PHI relates and to incorporate any such amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures in accordance with HIPAA;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the United States Health and Human Services Secretary for the purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible);
- Ensure that, in accordance with HIPAA, only the employees or classes of employees or other persons specifically identified or designated by the Employer in the Adoption Agreement or in the Plan's HIPAA policies and procedures to receive PHI may be given access to PHI by the Employer;
- Ensure that any person(s) described above may only have access to, and use and disclose PHI for Plan administration functions that the Employer performs for the Plan; and
- Ensure that if any person(s) described above do not comply with this Policy and the Plan Document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Section 18.03 HIPAA SECURITY REQUIREMENTS APPLICABLE TO ELECTRONIC PHI

To ensure the Plan's compliance with the security requirements of HIPAA with respect to electronic PHI, the Employer further agrees that it will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

- Ensure that the adequate separation between the Plan and the Employer with respect to electronic PHI is supported by reasonable and appropriate security measures;

- Ensure that any agent to whom it provides electronic PHI agrees to implement reasonable or appropriate security measures to protect the electronic PHI; and

- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Section 18.04 EMPLOYER CERTIFICATION

The inclusion of subsections (18.02) and (18.03) above shall constitute certification to the Plan by the Employer, as Plan Sponsor, that such provisions have been incorporated into this Plan Document in accordance with applicable HIPAA regulations.