LITTLETON PUBLIC SCHOOLS SECTION 125 PLAN

(AS AMENDED AND RESTATED
EFFECTIVE AS OF JULY 1, 2020)

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LITTLETON PUBLIC SCHOOLS SECTION 125 PLAN

INTRODUCTION

The Employer has amended and restated the Littleton Public Schools Section 125 Plan ("Plan") effective July 1, 2020, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is an amendment and restatement of a Plan which was originally effective on January 1, 1988.

The intention of the Employer is that the Plan qualify as a "cafeteria plan" within the meaning of Code Section 125, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Code Section 125(a) and other applicable sections of the Code. The Health Flexible Spending Account is intended to qualify under Code Sections 105 and 106, and is considered to be a separate plan to the extent required or permitted by law. The Dependent Care Flexible Spending Account is intended to qualify under Code Section 129, and is considered to be a separate plan to the extent required or permitted by law. This Plan is a governmental plan not subject to Title I of ERISA. The Health Savings Account funding feature described in Article VIII is not intended to establish an ERISA plan. The Plan shall be interpreted and operated in accordance with such intentions.

ARTICLE I
DEFINITIONS

1.1 **"Administrator"** means the person (which may be an individual or entity) appointed by the Employer to carry out the administration of the Plan. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefits. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

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

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

(b) Number of Dependents. Events that change a Participant'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 Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan;

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

(e) Change in Residence. A change in the place of residence of the Participant or his or her Spouse or Dependents.

1.6 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

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

1.8 **"Dependent"** means:

(a) for purposes of accident or health coverage (to the extent funded under the Premium Reimbursement Account component, and for purposes of the Health Flexible Spending Account component),

(1) a dependent as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof;

(2) any child (as defined in Code Section 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27; and

(3) any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding a child of divorced or separated parents who receives more than half of his or her support for the calendar year from one or both parents and is in the custody of one or both

parents for more than half of the calendar year) is treated as a dependent of both parents;

Notwithstanding the foregoing, the Health Flexible Spending Account component will provide benefits in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of "Dependent"; and

(b) for purposes of the Dependent Care Flexible Spending Account component, a Dependent is a Qualifying Dependent as defined in Section 7.2(d).

1.9 **"Effective Date"** means July 1, 2020; the original effective date was January 1, 1988.

1.10 **"Election Period"** means, with respect to a Plan Year, the month of May in the year preceding the Plan Year, or such other period ending prior to the beginning of the Plan Year as may be prescribed by the Administrator. However, an Eligible Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.11 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1 and who is:

(a) in an introductory or regular position for 20 hours or more per week (or who is a 0.5 FTE, in the case of a licensed Employee);

(b) an Employee who was in a position described in Section 1.10(a) and who is being paid for the remainder of such Employee's contract for a licensed Employee or an administrator; or

(c) a "full-time employee" within the meaning of Treas. Reg. § 54.4980H-1(a)(21), as determined in the sole discretion of the Employer.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee or if such individual is a leased employee within the meaning of Code Section 414(n)(2). In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

1.12 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.13 **"Employer"** means Littleton Public Schools and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. Employer also means the Littleton Public Schools Foundation, Littleton Academy, and Littleton Preparatory Charter School; provided however, that when the Plan provides that the Employer has a certain power (e.g. the appointment of an Administrator, entering a contract with a third party insurer, or amendment or termination of the Plan), the term "Employer" shall mean the Plan Sponsor.

1.14 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.15 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan.

1.16 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

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

1.18 **"Plan"** means this instrument, including all amendments thereto.

1.19 **"Plan Sponsor"** means Littleton Public Schools.

1.20 **"Plan Year"** means the 12-month period beginning July 1 and ending June 30. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the Benefits described in Section 4.1(b).

1.22 **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured or self-insured Benefit is elected, sub-accounts shall be established for each type of insured or self-insured Benefit.

1.23 **"Premium Only Plan"** means the plan of benefits contained in Section 4.1(b) of this Plan, which provides for the payment of Premium Expenses on a pre-tax (or on an after-tax, if so designated) basis.

1.24 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1 on a pre-tax (or on an after-tax, if so designated) basis. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the accounts established under the Plan pursuant to the Participants' elections made under Article V.

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

1.26 **"Spouse"** means "spouse" as defined in an Insurance Contract or self-insured benefit plan (for purposes of that Insurance Contract or self-insured benefit plan only) or an

individual who is treated as a spouse under the Code. For purposes of the Plan, two individuals are "married" and are in a "marriage" if each is the other's Spouse.

Notwithstanding the foregoing, for purposes of the Dependent Care Flexible Spending Account a Participant shall not be considered to be married, and shall not be considered to have a spouse, if:

(a) the Participant is legally separated from his or her spouse under a divorce or separate maintenance decree; or

(b) the Participant, although married, files a separate federal income tax return, maintains as his or her home a household that is the principal place of abode of the Qualifying Dependent (as defined in Section 7.2(d)) for more than one-half of the calendar year, furnishes over half of the cost of maintaining such household for the calendar year, and, during the last six (6) months of such calendar year, the Participant's spouse is not a member of such household.

1.27 **"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all regulations promulgated pursuant thereto.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder the first day of the month following 30 days of employment with the Employer. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall, subject to Sections 2.4 and 2.5, continue to be eligible to participate in the Plan. An Eligible Employee returning from a FMLA leave of absence pursuant to Section 12.15 shall be eligible to immediately participate if such Eligible Employee was a Participant in the Plan prior to the date of his or her first day of FMLA leave of absence. An Eligible Employee returning from an unpaid non-FMLA leave of absence shall also be eligible to immediately participate if such Eligible Employee was a Participant in the Plan prior to the date of his or her first day of non-FMLA leave, unless such Eligible Employee terminated his or her coverage or did not pay his or her share of the premium during the unpaid non-FMLA leave of absence, in which case such Eligible Employee shall be eligible to participate hereunder the first day of the month following 30 days of his or her return to work with the Employer.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the first day of the month coinciding with or next following the date on which he or she met the eligibility requirements of Section 2.1.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate and election of benefits form which the Administrator shall furnish to the Employee. The election made on such form shall be

irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his or her Benefit elections pursuant to Sections 5.4 and 5.5 hereof.

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

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured or self-insured Benefits described in Section 4.1(b) under this Plan shall automatically become a Participant and shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit Options, unless the Employee elects during the Election Period to either not participate in the Plan or to pay such premiums on an after-tax basis, or such Benefits are required to be paid on an after-tax basis.

2.4 TERMINATION OF PARTICIPATION

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

(a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.6;

(b) **End of Plan Year for Limited Participant.** The end of the Plan Year during which the Employee became a limited Participant because of a change in employment status pursuant to Section 2.5;

(c) **Death.** The Participant's death, subject to the provisions of Section 2.7; or

(d) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 11.2.

2.5 CHANGE OF EMPLOYMENT STATUS

Subject to Sections 12.15 and 12.17 (regarding FMLA and USERRA, respectively), if a Participant ceases to be eligible to participate because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further Salary Redirection may be made on behalf of the Participant with respect to the plan or plans for which the Participant is no eligible for, and, all further Benefit elections shall cease, subject to the limited Participant's right to continue coverage under any contracts. However, any balances in the limited Participant's Dependent Care Flexible Spending Account (as defined in Section 7.2(a)) may be used during such Plan Year to reimburse the limited Participant for any allowable Employment-Related Dependent Care Expenses (as defined in Section 7.2(c)) incurred during the Plan Year. Subject to the provisions of Section 2.6 and 2.9, if the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided he or she otherwise satisfies the participation requirements set forth in this

Article II as if he or she were a new Employee and made an election in accordance with Section 5.1.

2.6 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his or her participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Insured or Self-Insured Benefits.** With regard to Benefits provided under Section 4.1(b), the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Benefit for which premiums have already been paid.

(b) **Dependent Care Flexible Spending Account.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for Employment-Related Dependent Care Expenses (as defined in Section 7.2(c)) for claims incurred through the remainder of the Plan Year in which such termination occurs and submitted within 90 days after the end of the Plan Year, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **Health Flexible Spending Account treatment.** In the event a Participant terminates his or her participation in the Health Flexible Spending Account during the Plan Year, if Salary Redirection Contributions are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

(d) **Health Savings Account.** With regard to the Health Savings Account, distributions and all other matters are outside of this Plan and are to be handled by the Participant and his or her trustee/custodian in accordance with the agreement between them as described in Article VIII.

(e) **Further rights.** This Section shall be applied and administered consistent with such further rights a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B and Section 12.14 of the Plan.

2.7 DEATH

If a Participant dies, his or her participation in the Plan shall cease. However, such deceased Participant's personal representative may submit claims for reimbursement with respect to Employment-Related Dependent Care Expenses under the Dependent Care Flexible Spending Account incurred prior to the Participant's death for the Plan Year of the Participant's death. Such claims must be submitted within 90 days after the end of the Plan Year.

2.8 HEALTH FLEXIBLE SPENDING ACCOUNT REIMBURSEMENTS AFTER TERMINATION OF PARTICIPATION

Except as otherwise provided in this Section 2.8, the Participant will not be able to receive reimbursements for Medical Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Expenses incurred during the Plan Year prior to the date that the Participant ceases to be eligible, provided that the Participant (or the Participant's estate) files a claim within 90 days after the end of the Plan Year.

Notwithstanding any provision to the contrary in this Plan and, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, whose coverage terminates under the Health Flexible Spending Account because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health Flexible Spending Account the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Health Flexible Spending Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health Flexible Spending Account Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year, except that qualified beneficiaries who continue coverage through the end of the Plan Year may carry over up to $500.00 of unused Health Flexible Spending Account amounts remaining at the end of such Plan Year in accordance with the Plan's provisions regarding any Carryover Amount. Such continuation coverage shall be subject to all conditions and limitations under COBRA, except that it shall not be terminated early for after-acquired group health coverage or Medicare entitlement.

Except as otherwise provided herein, contributions for COBRA coverage for Health Flexible Spending Account Benefits shall be paid on an after-tax basis.

2.9 PARTICIPATION FOLLOWING TERMINATION OF EMPLOYMENT OR LOSS OF ELIGIBILITY

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired as an Eligible Employee within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire. Notwithstanding the above, an election to participate in the Salary Redirection for Insured or Self-Insured Benefits will be reinstated only to the extent that coverage under the Insured or Self-Insured Benefits are reinstated. Likewise, an HSA Benefit election will only be reinstated if an individual is an HSA-Eligible Individual. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, Section 2.5 shall apply.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 EMPLOYER AND SALARY REDIRECTION CONTRIBUTIONS

(a) **Employer Contributions.** For Participants who elect Health Insurance, Dental Benefits and/or Vision Insurance Benefits as described in Article IV, the Employer may contribute a portion of the contributions. There are no Employer contributions for Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits. The Employer may make a nonelective discretionary Employer contribution on behalf of Participants in the Health Savings Account.

(b) **Salary Redirection Contributions.** Benefits under the Plan shall be financed by pre-tax Salary Redirection Contributions sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his or her pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the accounts established under the Plan pursuant to the Participants' elections made under Article V.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the

remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury or with respect to the rules in Section 5.5(l) for a Health Savings Account. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants according to procedures and priorities established by the Employer. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirection Contributions be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirection Contributions are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirection Contributions to the Health Flexible Spending Account are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirection Contributions pursuant to Section 2.5.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

(a) Each Participant may elect to have the amount of his or her Cafeteria Plan Benefit Dollars applied to any one or more of the following optional Benefits:

(1) Health Flexible Spending Account ("Health FSA") Benefit

(A) General Purpose Health FSA Option – all eligible medical expenses

(B) Limited Purpose FSA Option (dental/vision only) for Participants who elect the Health Savings Account Benefit

(2) Dependent Care Flexible Spending Account Benefit

(3) Health Savings Account ("HSA") Benefit

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited Purpose FSA Option is selected.

(b) In addition, and subject to Section 4.9, each Participant shall have a sufficient portion of his or her Cafeteria Plan Benefit Dollars applied to the following Benefits under the Premium Only Plan unless the Participant elects not to receive such Benefits:

(1) Health Insurance Benefit

(2) Dental Benefit

(3) Vision Insurance Benefit

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 HEALTH SAVINGS ACCOUNT BENEFIT

Each Participant may elect to have pre-tax Salary Redirection contributions contributed to a health savings account, as defined in Code Section 223, and the amounts shall be subject to the terms of the health savings account established by the Participant.

4.5 HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.6 DENTAL BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental benefit. In addition, the Participant may elect such coverage as the Employer provides under such dental benefit.

(b) **Employer selects dental plan(s).** The Employer may select suitable dental plan(s) for use in providing this dental benefit, which will provide uniform benefits for all Participants electing this Benefit.

(c) **Dental plan(s) incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental plan(s) shall be determined therefrom, and such dental plan(s) shall be incorporated herein by reference.

4.7 VISION INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect such coverage as the Employer provides under such vision Insurance Contract.

(b) **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

4.8 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable

Benefits for the Plan Year shall have his or her non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his or her non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

4.9 INSUFFICIENT CAFETERIA PLAN BENEFIT DOLLARS

In the event that a Participant's Cafeteria Plan Benefit Dollars for a payroll period would be less than the Participant's premiums for all of the benefits described in Section 4.1(b), the following shall apply.

(a) If the Cafeteria Plan Benefit Dollars available for such payroll period would not be sufficient to pay the Participant's premium for the Health Insurance Benefit for such payroll period (and the Participant has elected such Benefit but neither the Dental Benefit nor the Vision Benefit), the Participant's Salary Redirection for such payroll period shall be reduced to zero.

(b) If the Cafeteria Plan Benefit Dollars available for a payroll period would be sufficient to pay the Participant's premium for the Health Insurance Benefit only (and the Participant has elected such Benefit), Cafeteria Plan Benefit Dollars shall be applied to the Health Insurance Benefit premium only.

(c) If, after the application of (b) above, the Cafeteria Plan Benefit Dollars available for such payroll period would also be sufficient to pay the Participant's premium for the Dental Benefit (and the Participant has elected such Benefit), Cafeteria Plan Benefit Dollars shall be applied to the Dental Benefit premiums.

(d) If, after the application of (b) and (c) above, the Cafeteria Plan Benefit Dollars available for such payroll period would also be sufficient to pay the Participant's premium for the Vision Insurance Benefit as well (and the Participant has elected such Benefit), Cafeteria Plan Benefit Dollars shall be applied to the Vision Insurance Benefit premiums

(e) After the application of (b), (c), and (d) above, the Participant's Salary Redirection for such payroll period shall be reduced to the amount required to apply Cafeteria Plan Benefit Dollars to the premiums described in (b), (c), and (d) above, as applicable.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he or she elects to do so on or before his or her effective date of participation pursuant to Section 2.2. However, if such Employee does not complete an application to participate and benefit election form and deliver it to the Administrator before such date, his Election Period shall extend 30 calendar days after such date, or for such further period as the Administrator shall determine and apply on a uniform and nondiscriminatory basis. However, any election during the extended 30 day election period pursuant to this Section 5.1 shall not be effective until the first pay period following the later of such Participant's effective date of participation pursuant to Section 2.2 or the date of the receipt of the election form by the Administrator, and shall be limited to the Benefit expenses incurred for the balance of the Plan Year for which the election is made.

Notwithstanding the foregoing but subject to Section 4.9, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured or self-insured Benefits described in Section 4.1(b) under this Plan shall automatically become a Participant and shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit Options, unless the Employee elects, during the Election Period to either not participate in the Plan or to pay such premiums on an after-tax basis, or such Benefits are required to be paid on an after-tax basis.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit Options he or she wishes to select and purchase with his or her Cafeteria Plan Benefit Dollars. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his or her participation in the Plan by notifying the Administrator in writing during the Election Period that he or she does not want to participate in the Plan for the next Plan Year; and

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Sections 5.4 and 5.5.

5.3 FAILURE TO ELECT

Any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be treated in the following manner:

(a) With regard to Benefits available under Sections 4.1(a)(1) and 4.1(a)(2) of the Plan, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirection Contributions shall therefore be authorized or made for the subsequent Plan Year for such Benefits.

(b) With regard to Benefits available under Section 4.1(b) of the Plan, and with regard to Health Savings Account Benefits previously elected, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options, unless the Participant has affirmatively rejected participation in the Plan.

5.4 PROCEDURE FOR MAKING NEW ELECTION IF EXCEPTION TO IRREVOCABILITY APPLIES

(a) **Timeframe for Making New Election**. A Participant (or an Eligible Employee who, when first eligible or during the open enrollment period declined to be a Participant) may make a new election within 31 days of the occurrence of an event described in Section 5.5 (or within 60 days of the occurrence of an event described in Section 5.5(b)(3) or (4)), as applicable, but only if the election is made on account of and is consistent with the event. Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Health, Dental or Vision Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 31-day period.

(b) **Effective Date of New Election**. Elections made pursuant to this Section 5.4 shall be effective for the balance of the period of coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 5.5(b) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only.

5.5 EVENTS PERMITTING EXCEPTION TO IRREVOCABILITY RULE

A Participant may change an election as described below upon the occurrence of the stated events for the applicable component of this Plan:

(a) **Change in Status (Premium Only Plan, Health Flexible Spending Account as Limited Below, and Dependent Care Flexible Spending Account as Limited Below).** A Participant may change his or her election under the Plan upon the occurrence of a Change in Status, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a

Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may not be made to reduce Health Flexible Spending Account coverage during a period of coverage; however, election changes may be made to cancel Health Flexible Spending Account coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health Flexible Spending Account coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health Flexible Spending Account coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health Flexible Spending Account to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing Internal Revenue Service guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) Loss of Spouse or Dependent Eligibility. For a Change in Status involving a Participant's divorce, annulment, or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (i) the Spouse involved in the divorce, annulment, or legal separation; (ii) the deceased Spouse or Dependent; or (iii) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status.

(2) Loss of Spouse or Dependent Eligibility Due to Change in Employment Status. For a Change in Status involving a change in employment status, if the eligibility conditions of a cafeteria plan or other employee benefit plan of the employer of a Participant's Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status (including a termination of employment) with the consequence that the individual ceases to be eligible under the other employer's plan, a Participant may elect to add accident or health insurance coverage for (i) the Spouse, or (ii) the Dependent.

(3) Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a

cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Administrator has reason to believe that the Participant's certification is incorrect.

(4) Special Consistency Rule for Dependent Care Flexible Spending Account Benefits. With respect to the Dependent Care Flexible Spending Account Benefits, a Participant may change or terminate his or her election upon a Change in Status if (i) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (ii) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code Section 129.

(b) **HIPAA Special Enrollment Rights (Premium Only Plan for the Health Insurance Benefit).** If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:

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

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

(3) the Participant or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

(4) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a

state children's health insurance program with respect to coverage under the group health plan.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 31 days). For purposes of Section 5.5(b), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that include the individual.

(c) **Certain Judgments, Decrees, or Orders (Premium Only Plan and Health Flexible Spending Account).** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody, (including a qualified medical child support order), which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires another individual (including the Participant's Spouse and the former Spouse) to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid (Premium Only Plan and Health Flexible Spending Account as Limited Below).** Notwithstanding subsection (a), if a Participant or a Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health Flexible Spending Account may be cancelled (but not reduced). Notwithstanding the foregoing, such

cancellation will not become effective to the extent that it would reduce future contributions to the Health Flexible Spending Account to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect to commence or increase accident or health coverage of the individual who loses Medicaid or Medicare eligibility and/or the Participant's Health Flexible Spending Account coverage may commence or increase.

(e) **Cost increase or decrease (Premium Only Plan).** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirection Contributions of all affected Participants for such Benefit. Alternatively, if the Administrator determines that the cost changed to a benefit package option significantly increases, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of Salary Redirection Contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Significant Curtailment of Coverage (Premium Only Plan).** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or if a significant curtailment with a loss of coverage, drop coverage prospectively if no similar coverage is offered.

(g) **Addition or Significant Improvement of a Benefit Option (Premium Only Plan).** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans (Premium Only Plan).** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans (Premium Only Plan).** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if:

(1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or

(2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in dependent care provider (Dependent Care Flexible Spending Account).** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 129(c).

(k) **Health Flexible Spending Account cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under this subsection.

(l) **Health Savings Account Benefit prospective elections.** With regard to the Health Savings Account Benefit specified in Section 4.4, a Participant who has elected to make pre-tax Salary Redirection Contributions under such arrangement may modify or revoke the election prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder.

(m) **Special Election Changes Under Notice 2014-55 (Premium Only Plan).** Subject to (3) and (4) of this subsection, a Participant may prospectively revoke his or her Salary Redirection Agreement with respect to participation in the Health Insurance Benefit described in Section 4.5 pursuant to (1) or (2) of this subsection.

(1) A Participant may prospectively revoke his or her Salary Redirection Agreement election with respect to participation in the Health Insurance Benefit that is a group health plan that is not a Health FSA and that provides minimum essential coverage ("MEC Health Insurance Benefit") if:

(A) 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 the 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 to participate under the MEC Health Insurance Benefit; and

(B) The revocation of the election of coverage under such MEC Health Insurance Benefit corresponds to the intended enrollment of the Participant, and any related individuals whose MEC Health Insurance Benefit coverage would cease due to such 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.

(2) A Participant may prospectively revoke his or her Salary Redirection Agreement election with respect to participation in the MEC Health Insurance Benefit if:

(A) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(B) The revocation of the election of coverage under such MEC Health Insurance Benefit corresponds to the intended enrollment of the Participant, and any related individuals whose MEC Health Insurance Benefits coverage would cease due to such revocation, in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

(3) A Participant must provide reasonable proof that he or she is eligible to revoke a Salary Redirection Agreement described in this subsection at the time he or she makes such revocation.

(4) The terms "minimum essential coverage," "Special Enrollment Period," "Qualified Health Plan," "Marketplace," and "Department of Health and Human Services," where used in this subsection, shall have the meaning given to such terms in Notice 2014-55. This subsection shall be interpreted to be compliant with Notice 2014-55.

5.6 SPECIAL ELECTION CHANGES FOR DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS ON OR BEFORE DECEMBER 31, 2020

The provisions of this Section 5.6 are effective June 1, 2020 and apply only to election changes with respect to Dependent Care Flexible Spending Accounts.

(a) Subject to this Section 5.6, a Participant may change his or her election under the Plan for an event that materially affects the cost or availability of dependent care for which the Participant incurs, will incur, or would have incurred Employment-Related Dependent Care Expenses without regard to whether such event is a Change in Status. For this purpose, the fact that a Participant has or will have a Prior Year Dependent Care Amount (see Section 7.14) is such an event.

(b) The change in election must be on account of and be consistent with the event described in (a) above. The Administrator may request proof of the event and a description of how the change in election is consistent with such event. The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether to permit a requested change.

(c) Subject to (e) below, changes in election pursuant to this Section 5.6 shall be made in anticipation of an event described in (a) above (but only if such event is reasonably likely to occur), but no later than 60 days after the occurrence of the event described in (a) above.

(d) Changes in election pursuant to this Section 5.6 shall be prospective only and must be made prior to the beginning of the month for which the change will be effective.

(e) No changes in election pursuant to this Section 5.6 may be made after December 31, 2020.

5.7 SPECIAL ELECTION CHANGES FOR HEALTH FLEXIBLE SPENDING ACCOUNTS ON OR BEFORE DECEMBER 31, 2020

The provisions of this Section 5.7 are effective June 1, 2020 and apply only to election changes with respect to Health Flexible Spending Accounts.

(a) Subject to this Section 5.7, a Participant may cancel or reduce his or her election under the Plan if the Participant has been furloughed by the Employer.

(b) No cancellation or reduction of an election may be made under this Section 5.7 if the Participant's Health Flexible Spending Account balance is negative.

(c) Changes in election pursuant to this Section 5.7 shall be prospective only and must be made prior to the beginning of the month for which the change will be effective.

(d) No changes in election pursuant to this Section 5.7 may be made after December 31, 2020.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

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

6.2 DEFINITIONS

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

(a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

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

(1) General Purpose Health Flexible Spending Account Option. For purposes of this Option, Medical Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code Section 213(d), and as allowed under Code Sections 105 and 106 and the Treasury regulations, but only to the extent that the expense has not been reimbursed through insurance or otherwise. If only a portion of a Medical Expense has been reimbursed elsewhere (e.g., because the Health Insurance or Dental Plan imposes co-

payment or deductible limitations), then the Health Flexible Spending Account can reimburse the remaining portion of such Medical Expense if it otherwise meets the requirements of this Article VI. Medical Expenses include expenses incurred on or after January 1, 2020, to purchase over-the-counter medicines or drugs for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or functions of the body, and that otherwise meet all of the requirements of the first complete sentence under this Option, and also include expenses incurred for menstrual care products, as defined in Code Section 223(d)(2)(D). Notwithstanding the foregoing, the term Medical Expenses does not include:

(A) premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer); or

(B) cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease).

The Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Expenses and may limit reimbursement of expenses described in such procedures.

(2) Limited Purpose Flexible Spending Account Option (Dental/Vision Only). For purposes of this Option, Medical Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care as defined in Code Section 213(d) and as further described under the General Purpose Health Flexible Spending Account Option—provided, however, that such expenses are for dental care or vision care (as defined in Code Section 223(c)) only.

Health Savings Account Benefits cannot be elected with Health Flexible Spending Account Benefits unless the Limited Purpose Flexible Spending Account Option (Dental/Vision Only) is selected.

A Participant who contributes to a Health Savings Account may only be reimbursed for medical expenses that are considered to be for dental care or vision care only expenses under the Limited Purpose Flexible Spending Account Option as allowed under Code Section 223.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

6.3 FORFEITURES

The amount in the Health Flexible Spending Account that exceeds the Carryover Amount (as defined below) as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 9.2.

The "Carryover Amount" is the amount, not to exceed the IRS Carryover Limit with respect to a Plan Year, that remains in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) and such Carryover Amount shall be available in the Plan Year subsequent to the Plan Year from which the Carryover Amount was derived. In determining the Carryover Amount, the Plan shall be administered in accordance with IRS Notice 2013-71 and administered so as to avoid, to the extent possible, any forfeiture. The Carryover Amount may not be cashed out or converted to any other taxable or nontaxable benefit and will not affect the maximum dollar limit otherwise creditable to a Health Flexible Spending Account pursuant to the Participant's election form/Salary Redirection Agreement. Medical Expenses incurred in the current Plan Year will be reimbursed first from a Participant's unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. The Carryover Amounts that are used to reimburse a current Plan Year expense will reduce the amount available to pay the Participant's preceding Plan Year expenses during the claims run-out period, cannot exceed the IRS Carryover Limit, and will count against the maximum Carryover Amount.

The "IRS Carryover Limit" shall be $500.00 with respect to the Plan Year beginning July 1, 2019, and $550.00 with respect to subsequent Plan Years; provided, however, that for Plan years beginning on or after July 1, 2021, the IRS Carryover Limit shall be an amount as adopted or designated by the Administrator, but not to exceed the maximum amount permitted by IRS guidance.

Notwithstanding the foregoing, a Participant who is a participant in a health savings account for a Plan Year, or any portion thereof, shall be deemed to have elected to have the Carryover Amount, if any, carried over to a limited purpose health flexible savings account (if the Plan provides a limited purpose health flexible savings account that a Participant who participates in a health savings account is eligible to participate in) or, if the Plan does not provide such a limited purpose health flexible savings account, the Carryover Amount with respect to such Participant shall be zero.

6.4 LIMITATION ON ALLOCATIONS

(a) No more than $2,600 (and increased to $2,650 effective July 1, 2018) may be allocated to the Health Flexible Spending Account by a Participant in or on account of any plan year. Such maximum amount may be adjusted by the Administrator for any cost-of-living adjustment described in Code Section 125(i)(2) in the Administrator's sole discretion.

(b) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory maximum limit (as indexed under Code Section 125(i)(2) for cost-of-living adjustments for Plan Years beginning after December 31, 2013). If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total health flexible spending account contributions under all of the cafeteria plans are limited to the statutory maximum limit (as indexed under Code Section 125(i)(2) for cost-of-living adjustments for Plan Years beginning after December 31, 2013). However, a Participant employed by two or more employers that are not members of the same controlled group may elect to contribute up to the statutory maximum limit (as indexed under Code Section 125(i)(2) for cost-of-living adjustments for Plan Years beginning after December 31, 2013), subject to each employer's health flexible spending account maximum contribution limit.

(c) **Carryover.** A Carryover Amount with respect to a Plan Year shall not affect the maximum Salary Redirection amount specified for the subsequent Plan Year. Carryover Amounts may not be cashed out or converted to any other taxable or nontaxable benefit.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the Health Flexible Spending Account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the Health Flexible Spending Account equals the amount designated for the Health Flexible Spending Account by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

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

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents shall be reimbursed during the Plan Year subject to Section 2.6, even though the submission of such a claim occurs after his or her participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the Health Flexible Spending Account at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his or her Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

6.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator or its designated Service Provider ("Service Provider") and applied in a uniform nondiscriminatory manner, use a debit and/or credit (stored value) card ("card" or "cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.4.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator and/or Service Provider shall also follow the requirements set forth in Revenue Ruling 2003-43, Notice 2006-69, Notice 2010-59 and Notice 2011-5, effective as of the dates specified therein, and as may be subsequently amended by future guidance. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator or Service Provider, to not qualify as a Medical Expense, the Administrator or Service Provider, in its discretion, shall use one of the following

correction methods to make the Plan whole. Until the amount is repaid, the Administrator or Service Provider shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

6.9 QUALIFIED RESERVIST DISTRIBUTION

Notwithstanding any other provision of the Plan to the contrary, and to reflect the Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART Act"), a Participant may elect to receive a distribution of certain amounts from his or her Health Flexible Spending Account for a Plan Year, subject to the following provisions.

(a) **Effective Date.** Qualified Reservist Distributions ("QRDs") are added to the Plan effective as of July 1, 2009.

(b) **Distribution Limit.** The maximum amount that may be distributed as a QRD to a Participant is the amount contributed by the Participant to the Health Flexible Spending Account as of the date of the QRD request less any Health Flexible Spending Account reimbursements received as of the date of the QRD request. Notwithstanding any other provision of the Plan to the contrary, this portion of the Participant's balance may be distributed without regard to whether Medical Expenses have been incurred. Any portion of the distribution that is not a reimbursement for substantiated Medical Expenses will be included in the Participant's gross income and wages.

(c) **Number of Distributions.** There is no limit on how many requests may be made in a Plan Year.

(d) **Claims Process.** Claims incurred and submitted prior to the date of the payment of the QRD shall be paid as any other claim. Claims incurred or submitted after the date the QRD is paid shall not be paid. The Participant's right to submit a claim is terminated as of the date of the QRD request.

(e) **Ability to elect QRD.** All Participants may request a QRD provided the provisions of this section are satisfied.

(f) **Definition of QRD.** A QRD means any distribution to a Participant of all or a portion of the balance in the Participant's Health Flexible Spending Account if both (1) and (2) below are satisfied.

(1) Such Participant is a member of a reserve component (as defined in Section 101 of Title 37, United States Code) and is ordered or called to active duty for a period of 180 days or more or for an indefinite period, according to the following:

(A) A Participant who was called or ordered to duty prior to July 1, 2009 is eligible to request a QRD provided the individual's period of active duty continues after July 1, 2009 and meets the duration requirement in (1) above.

(B) A QRD may only be made if the Participant is ordered or called to active duty, not the Participant's spouse or dependents.

(C) Eligibility for a QRD is not affected if the order or call is for 180 days or more or is indefinite, even if the actual period of active duty is less than 180 days or is changed otherwise from the order or call.

(D) If the period specified in the order or call is less than 180 days, then no QRD is permitted. However, if there are subsequent calls or orders that increase the total period of active duty so that it meets the duration requirement of (1) above, then the Participant may request a QRD as of the date of such subsequent calls or orders.

(2) The request for the distribution is made during the period beginning on the date of the order or call that applies to the Participant and ending on the last day of the Plan Year which includes the date of such order or call.

(g) **Conditions.**

(1) The Employer must receive a copy of the order or call to active duty and may rely on the order or call to determine the period that the Participant has been ordered or called to active duty.

(2) In general, QRDs are only permitted prospectively after the Plan is amended to permit QRDs. However, QRDs are permitted prior to the time the Plan is amended to permit QRDs provided:

(A) the Plan is retroactively amended by December 31, 2009, and

(B) the amendment is retroactively effective to the date of the first QRD paid under the Plan, but not prior to July 1, 2009.

(3) A QRD may only be made with respect to a Participant's Health Flexible Spending Account balance in existence on or after July 1, 2009. A QRD may not be made with respect to amounts:

(A) forfeited on or before July 1, 2009,

(B) attributable to a prior Plan Year (including a Plan Year ending on or before July 1, 2009), or

(C) attributable to a non-health flexible spending account.

(h) **Time of Request.** The QRD request must be made on or after the call or order and before the last day of the Plan Year. The QRD shall be paid within a reasonable time but in no event more than 60 days after the date of the request.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF PLAN

This Dependent Care Flexible Spending Account is intended to qualify as a plan under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this plan may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed under this Dependent Care Flexible Spending Account shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as

having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

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

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes, an individual who meets at least one of the following tests:

(1) a Participant's "qualifying child" (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Participant's dependent, as defined in Code Section 152 determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, or the Spouse of a Participant, who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

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

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year (or portion thereof during which he or she is a Participant) and, pursuant to Section 7.14 and only for the Plan Year beginning on July 1, 2019, during the 2020 Grace Period.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus (except as otherwise described in and pursuant to Section 7.14 and only for the Plan Year beginning on July 1, 2019, with respect to the 2020 Grace Period). In the event of a forfeiture under this Section 7.8, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a

Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

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

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to

verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he or she wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

7.13 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator or its designated Service Provider ("Service Provider") and applied in a uniform nondiscriminatory manner, use a debit and/or credit (stored value) card ("card" or "cards") provided by the Administrator and the Plan for payment of Employment-Related Dependent Care Expenses, subject to the following terms:

(a) **Card only for dependent care expenses.** Each Participant issued a card shall certify that such card shall only be used for Employment-Related Dependent Care Expenses. The Participant shall also certify that any Employment-Related Dependent Care Expense paid with the card has not already been reimbursed by any other plan covering dependent care benefits and that the Participant will not seek reimbursement from any other plan covering dependent care benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Dependent Care Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Dependent Care Flexible Spending Account.

(c) **Only available for use with certain service providers.** The cards shall only be accepted by such service providers as have been approved by the Administrator. The cards shall only be used for Employment-Related Dependent Care Expenses from these providers.

(d) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator and/or Service Provider shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(e) **Correction methods.** If such purchase is later determined by the Administrator or Service Provider to not qualify as an Employment-Related Dependent Care Expense, the Administrator or Service Provider, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator or Service Provider shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

7.14 2020 GRACE PERIOD

Notwithstanding any contrary provision in this Plan and subject to the conditions of Section 7.9 and this Section 7.14, a Participant may be reimbursed for Employment-Related Dependent Care Expenses incurred during the 2020 Grace Period from amounts remaining in his or her Dependent Care Flexible Spending Account at the end of the Plan Year beginning July 1, 2019, (the "**Prior Year Dependent Care Amount**") if he or she Is a Participant in the Plan with Dependent Care Flexible Spending Account coverage that is in effect on June 30, 2020.

A Prior Year Dependent Care Amount may not be cashed out or converted to any other taxable or nontaxable benefit.

Employment-Related Dependent Care Expenses incurred during the 2020 Grace Period and approved for reimbursement in accordance with Section 7.12 (other than 7.12(i)) shall be reimbursed first from any available Prior Year Dependent Care Amount and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year beginning July 1, 2020. A Participant's Prior Year Dependent Care Amount shall be debited for any reimbursement of Employment-Related Dependent Care Expenses incurred during the 2020 Grace Period that is made from such Prior Year Dependent Care Amount.

Claims for reimbursement of Employment-Related Dependent Care Expenses incurred during the 2020 Grace Period from the Prior Year Dependent Care Amount must be submitted within 90 days after the end of the 2020 Grace Period. Any Prior Year Dependent Care Amounts that remain after all reimbursements have been made for the Plan Year beginning July 1, 2019, and the 2020 Grace Period shall not be carried over to reimburse the Participant for expenses incurred after December 31, 2020.

Any amount credited to a Participant's Dependent Care Flexible Spending Account for the Plan Year beginning on July 1, 2019, that remains at the end of the 2020 Grace Period (and after the processing of all claims for such Plan Year and the 2020 Grace Period pursuant to Section 7.12 and this Section 7.14) shall be forfeited and credited to the benefit plan surplus, and the Participant shall have no further claim to such amount for any reason.

For purposes of this Plan, "**2020 Grace Period**" means the period beginning on July 1, 2020 and ending on December 31, 2020.

The provisions of this Plan regarding the 2020 Grace Period shall be administered in accordance with IRS Notice 2020-29 (and any subsequent IRS guidance).

ARTICLE VIII
HEALTH SAVINGS ACCOUNT

8.1 ESTABLISHMENT OF PLAN

This Health Savings Account ("HSA") is designed to permit an Eligible Employee to contribute on a pre-tax Salary Redirection basis to an Employee's HSA. The Employer may

also make contributions to the HSA. The HSA funding feature described in this Article VIII is not intended to establish an ERISA plan.

8.2 DEFINITIONS

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

(a) "**High Deductible Health Plan**" means a high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code Section 223(c)(2), as described in materials provided separately by the Employer. The High Deductible Health Plan may or may not be the sole health insurance plan eligible for pre-tax Salary Redirection funding hereunder.

(b) "**HSA**" means a health savings account established under Code Section 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

(c) "**HSA Benefits**" has the meaning described in Section 8.3.

(d) "**HSA-Eligible Individual**" means an individual who is eligible to contribute to an HSA under Code Section 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer.

8.3 HSA BENEFITS

An Eligible Employee can elect to participate in the HSA by electing to pay the contributions on a pre-tax Salary Redirection basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA Benefits offered under the Plan). As described in Section 5.5, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed; provided however, in the event the Eligible Employee has not established an HSA with a trustee/custodian, any pre-tax Salary Redirection Contributions that were withheld from an Employee's Compensation shall be returned to the Employee upon a return of such Contributions to the Employer.

HSA Benefits cannot be elected with Health Flexible Spending Account Benefits unless such benefits are limited as described in Section 4.1(a)(1)(B).

8.4 CONTRIBUTIONS FOR COST OF COVERAGE FOR HSA; MAXIMUM LIMITS

The annual contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant and any Employer Contribution. In no event shall the amount elected and/or contributed exceed the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made.

The Employer may make an additional nonelective Employer contribution to the HSA on a participant's behalf on a discretionary basis.

An additional catch-up contribution of $1,000 may be made for Participants who are age 55 or older by the close of the taxable year.

In addition, the maximum annual contribution shall be:

(a) reduced by any matching (or other Employer Contribution made on the Participant's behalf made under the Plan); and

(b) prorated for the number of months in which the Participant is an HSA-Eligible Individual.

8.5 RECORDING CONTRIBUTIONS FOR HSA

As described in Section 8.7, the HSA 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 HSA trustee/custodian, not the Employer, will establish and maintain the HSA. While the HSA trustee/custodian will be chosen by the Participant, not by the Employer, the Employer may however, limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax Salary Redirection – such limitation is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax Salary Redirection, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer shall have no authority or control over the funds deposited in a HSA.

8.6 TAX TREATMENT OF HSA CONTRIBUTIONS AND DISTRIBUTIONS

The tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.

8.7 TRUST/CUSTODIAL AGREEMENT; HSA NOT INTENDED TO BE AN ERISA PLAN

HSA Benefits under this Plan consist solely of the ability make contributions to the HSA on a pre-tax Salary Redirection basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code Section 223(d)(2). The Employer shall have no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Redirection contributions to an HSA, the HSA is not intended to be a benefit plan sponsored or maintained by the Employer that would be subject to the Employee Retirement Income Security Act of 1974, as amended.

ARTICLE IX
BENEFITS AND RIGHTS

9.1 CLAIM FOR BENEFITS

(a) **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

(b) **Dependent Care Flexible Spending Account or Health Flexible Spending Account claims.** Any claim for Dependent Care Flexible Spending Account or Health Flexible Spending Account Benefits shall be made to the Administrator or designated Service Provider ("Service Provider"). For the Health Flexible Spending Account Benefit, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator or Service Provider. For the Dependent Care Flexible Spending Account Benefit, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator or Service Provider. If the Administrator or Service Provider denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. If the Administrator or Service Provider does not notify the Participant of the denial of the claim within the 90-day period specified above, then the claim shall be deemed denied. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim procedure.

(c) **Appeal.** Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator or Service Provider for a full and fair review. The claimant or his or her duly authorized representative may:

(1) request a review upon written notice to the Administrator or Service Provider;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

(d) **Review of appeal.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless

special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3, Section 7.8 or Section 7.14, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his or her account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited on the 360th day after the payment first became due, and thereupon deposited in the benefit plan surplus pursuant to Section 6.3, Section 7.8 or Section 7.14, as applicable.

9.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses.

9.3 NONASSIGNABILITY OF RIGHTS

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

ARTICLE X
ADMINISTRATION

10.1 PLAN ADMINISTRATION

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan;

(f) To approve reimbursement requests and to authorize the payment of benefits;

(g) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

10.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

10.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be paid from the benefit plan surplus under Section 9.2 or borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

10.4 INSURANCE CONTROL CLAUSE

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

10.5 INDEMNIFICATION OF ADMINISTRATOR

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

10.6 EFFECT OF MISTAKE

In the event of a mistake as to eligibility for or participation in the Plan, the allocations made to the account of any person under the Plan, or the amount of benefits paid or to be paid to a Participant or other person under the Plan, the Administrator shall, to the extent it deems administratively possible and otherwise permissible under Code Section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or the Employer from compensation paid by an Employer to an Employee.

In the case of an employee who requests relief on the grounds of a mistaken election, relief under this Section 10.6 shall only be granted if there is clear and convincing evidence of such mistake (as for example because the employee has made an election to fund a Dependent Care Flexible Spending Account for a Plan Year but has no eligible dependents) and the employee requests and is granted relief prior to the end of the calendar year in which such mistaken election was made.

Notwithstanding the foregoing, any determination as to whether or how to correct a mistake or to grant relief with respect to a mistaken election under this Section 10.6 shall be in the sole discretion of the Administrator.

ARTICLE XI
AMENDMENT OR TERMINATION OF PLAN

11.1 AMENDMENT

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

11.2 TERMINATION

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract or other such documents shall be paid in accordance with the terms of the Insurance Contract or other such documents.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such account shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XII
MISCELLANEOUS

12.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 12.12.

12.2 GENDER AND NUMBER

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

12.3 WRITTEN DOCUMENT

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

12.4 EXCLUSIVE BENEFIT

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

12.5 PARTICIPANT'S RIGHTS

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

12.6 ACTION BY THE EMPLOYER

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

12.7 EMPLOYER'S PROTECTIVE CLAUSES

(a) **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

(b) **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

12.8 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

12.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

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

12.10 FUNDING

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

12.11 GOVERNING LAW

This Plan is governed by the Code, the Treasury regulations, and other guidance issued by the Department of the Treasury (as such may be issued or amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Colorado.

12.12 SEVERABILITY

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

12.13 CAPTIONS

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

12.14 CONTINUATION OF COVERAGE

Notwithstanding anything in the Plan to the contrary, a Participant and his or her Spouse and Dependents, as applicable, whose benefits coverage under this Plan become subject to the continuation coverage requirement of Code Section 4980B because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), will be entitled to continuation coverage as prescribed in Code Section 4980B. For purposes of Section 2.6,

Section 2.8, Section 5.5, and this Section 12.14, COBRA means the provisions requiring continuation of employer-sponsored group health coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (or the generally parallel continuation requirements provided under the Public Health Service Act) as may be amended from time to time. For the Health Flexible Spending Account, an individual shall be eligible for COBRA continuation coverage only if he or she has a positive Health Flexible Spending Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individual shall be notified if he or she is eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health Flexible Spending Account shall cease at the end of the Plan Year and cannot be continued for the next Plan Year.

12.15 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, the Plan shall be operated in accordance with the Family and Medical Leave Act, the regulations thereunder, and Treasury Regulation Section 1.125-3, in each case as amended from time to time.

12.16 COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

(a) **General.** The Plan is a hybrid entity, as defined by HIPAA. As a hybrid entity, the Health Flexible Spending Account (for purposes of this Section 12.16 referred to as "Health Plan") under this Cafeteria Plan is a health plan component subject to the applicable provisions of the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160-164, subparts A and E) (the "Privacy Standards") the Standards for Security of Electronic Protected Health Information (45 CFR Parts 160-164) (the "Security Standards") and the notification requirements for breach of unsecured protected health information under the Breach Notification Rule (45 CFR Part 164, subpart D). HIPAA and its implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), and the regulations promulgated thereunder by the U.S. Department of Health & Human Services, including but not limited to, the HIPAA Omnibus Rule (the "Final Rule") and other applicable federal and state laws, the provisions of which are incorporated herein by reference. HIPAA and its implementing regulations (as modified by the HITECH Act and the Final Rule) restrict the ability of the health plan components of the Plan to use and disclose protected health information ("PHI") and electronic protected health information ("Electronic PHI"). Members of the District's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is PHI. PHI means information that is created or received by the Plan and relates to:

(1) the past, present, or future physical or mental health or condition of an individual;

(2) the provision of health care to an individual; or

(3) the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for

which there is a reasonable basis to believe the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

Electronic PHI means PHI that is transmitted or maintained in electronic media. The Plan Sponsor shall have access to PHI and Electronic PHI from the Health Plan only as permitted under this Plan or as otherwise required or permitted by HIPAA. All terms defined in the HIPAA rules shall have the same meaning set forth therein. It is the Plan's policy to comply fully with HIPAA's requirements (to the extent applicable) with respect to the Health Plan. All further references in this subsection to the "Plan" are references to the health plan components.

(b) **Permitted Disclosure of Enrollment/Disenrollment Information.** Enrollment and disenrollment information created by the Plan Sponsor is not considered PHI, when the Plan Sponsor performs enrollment functions, it does so on behalf of participants and beneficiaries rather than on behalf of the Health Plan. In addition, in accordance with 45 CFR § 164.504(f)(1)(iii), the Health Plan (or business associate with respect to the Health Plan) may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Health Plan.

(c) **Permitted Uses and Disclosure of Summary Health Information.** Except as prohibited by 45 CFR § 164.502(a)(5)(i), the Health Plan (or business associate with respect to the Health Plan) may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of:

(1) obtaining premium bids from health plans for providing health insurance coverage under the Health Plan; or

(2) modifying, amending, or terminating the Health Plan.

"Summary Health Information" means information:

(1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and

(2) from which the information described at 45 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

(d) **Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes.** Unless otherwise permitted by law, and subject to the conditions set forth in subsection (e) below, the Health Plan or a business associate (and any health insurance issuer or HMO acting on behalf of the Health Plan) may disclose individuals' PHI and Electronic PHI to the Plan Sponsor provided that the Plan Sponsor uses or discloses such PHI and Electronic PHI only for health plan administration

purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, monitoring and Plan management (including financial and administrative oversight and HIPAA compliance). Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions. Notwithstanding the provisions of this Health Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 § CFR 164.504(f).

(e) **Conditions of Disclosure for Plan Administration Purposes.** Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information in accordance with (b) above, Summary Health Information in accordance with (c) above, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 § CFR 164.508, which are not subject to these restrictions) disclosed to it by the Health Plan (or a business associate on behalf of the Health Plan), Plan Sponsor shall:

(1) not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;

(2) ensure that any agents to whom it provides PHI received from the Health Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(3) not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(4) report to the Health Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which becomes aware;

(5) make available PHI in accordance with 45 CFR § 164.524;

(6) make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

(7) make available the PHI required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

(8) make its internal practices, books and records relating to the use and disclosure of PHI received from the Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with HIPAA's privacy requirements;

(9) if feasible, return or destroy all PHI received from the Health Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for

the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

(10) ensure that the adequate separation required in 45 CFR § 164.504(f)(2)(iii) is established;

(11) agree that if it creates, receives, maintains, or transmits any Electronic PHI (other than enrollment/disenrollment information disclosed pursuant to 45 CFR § 164.504(f)(1)(iii) and summary health information disclosed pursuant to 45 CFR § 164.504(f)(1)(ii) and information disclosed pursuant to a signed authorization that complies with the reference of 45 CFR § 164.508, which are not subject to these restrictions) on behalf of the Health Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Health Plan;

(12) ensure that the adequate separation required by 45 CFR § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(13) ensure that any agents to whom it provides this Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

(14) report to the Health Plan any security incident of which it becomes aware.

(f) **Adequate Separation Between Health Plan and the Plan Sponsor.**

The following classes of employees of the Plan Sponsor will have access to PHI and Electronic PHI received from the Health Plan (or from a health insurance issuer with respect to the Health Plan):

(1) Human Resources, Benefits and Payroll Personnel;

(2) Financial and Audit Personnel; and

(3) Programmers – Information and Technology Services Personnel.

No other persons shall have access to PHI. The listed classes of employees will have access to PHI solely to perform the Plan administration functions that the Plan Sponsor performs for the Plan. The Plan Sponsor will also ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to Electronic PHI on behalf of the Health Plan. They will be subject to disciplinary

action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of PHI or Electronic PHI in violation of Health Plan provisions. Further, the HIPAA Privacy Officer and/or the Security Official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such violation will recur.

(g) **Certification of the Plan Sponsor.** The Health Plan (or business associate acting on behalf of the Health Plan) shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Health Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth above.

12.17 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder regarding termination of coverage. In the event participation in medical and dental coverages offered through this Plan would terminate due to the Participant taking a USERRA leave of absence, such benefits shall be continued for the lesser of: the period of leave or twenty-four (24) months; provided, however, coverage will continue only as long as any required Employee contributions are timely made. Employees on a USERRA leave of less than thirty one (31) days must make the same contribution as is required for active Employees; Employees on a USERRA leave of thirty one (31) days or longer must pay up to 102% of the full cost (Employee and District contributions) of coverage, as determined by the Plan Administrator. The Participant must pay the required contribution (if any) on an after-tax basis as due.

12.18 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act as of the effective date thereof.

12.19 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act as of the effective date thereof. The Plan shall not use genetic information for underwriting purposes or disclose genetic information to any person or party. For purposes of this paragraph, "genetic information" and "underwriting purposes" shall have the meaning given to it in Section 105(a) of GINA and applicable guidance issued pursuant thereto.

12.20 USE OF ELECTRONIC MEDIA

The Employer or Administrator may use telephonic or electronic media to satisfy any notice or consent requirement to or from a Participant or beneficiary, and to conduct plan transactions such as enrolling Participants, making (and changing) Participant contribution elections, and other transactions.

22 IN WITNESS WHEREOF, this Plan document is hereby executed this day of June, 2020.

WITNESS:

By: Janet L Walworth

ARAPAHOE COUNTY SCHOOL DISTRICT NO. 6 dba LITTLETON PUBLIC SCHOOLS

By: Michael D. Jones

Michael D. Jones
Asst. Superintendent of Human Resources