FLEXIBLE BENEFIT PLAN

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Plan Document

Effective 01.01.2021
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1. PRELIMINARY MATTERS

1.1 *Form.* The Flexible Benefit Plan is set forth in this document, the accompanying Plan Highlights, which is incorporated herein by reference, and any amendments to these documents.

1.2 *Plan Purpose.* This Plan is intended, and shall be interpreted and administered, to comply with Section 125 of the Code and the regulations thereunder. The sole purpose of this Plan is to provide Qualified Benefits to Participants and it is maintained for their exclusive benefit.

2. DEFINITIONS

2.1 "*Account*" means an Adoption Assistance Flexible Spending Account, Dental Insurance Account, Dependent Care Flexible Spending Account, Disability Insurance Account, Health Insurance Account, Health Savings Account, Life Insurance Account, Medical Flexible Spending Account or Vision Insurance Account, established for a Participant.

2.2 "*Adoption Assistance Flexible Spending Account*" means an Account established for a Participant under the Plan for reimbursement of the Participant's Adoption Expenses as provided in Section 137 of the Code.

2.3 "*Adoption Expense*" means an adoption-related expense under the standards established in Section 23(d) of the Code.

2.4 "*Code*" means the Internal Revenue Code of 1986, as amended, and corresponding provisions of future laws as amended.

2.5 "*Committee*" means the committee of persons that may be appointed by the Employer to serve as the Plan Administrator in accordance with Section 6.

2.6 "*Dental Insurance*" means any written policy or program of group dental insurance coverage maintained by the Employer, whether provided through a self-insured or a fully-insured policy with a third-party carrier.

2.7 "*Dental Insurance Account*" means an Account established for a Participant under the Plan for payment of Dental Insurance premiums.

2.8 "*Dependent*" means a dependent as defined in Section 152 of the Code, except (i) for purposes of Dental, Health and Vision Insurance and reimbursements from a Medical Flexible Spending Account, (a) a dependent is defined as in Section 105(b) of the Code, and (b) any child to whom Section 152(e) of the Code applies is treated as a dependent of both parents, and (ii) for purposes of Dependent Care Expenses, it means a Qualifying Individual.

2.9 "*Dependent Care Expense*" means an employment-related expense necessary for gainful employment of the Participant under the standards established in Section 21(b) of the Code.

2.10 "*Dependent Care Flexible Spending Account*" means an Account established for a Participant under the Plan for reimbursement of the Participant's Dependent Care Expenses.

2.11 "*Disability Insurance*" means any written policy or program of group disability insurance coverage maintained by the Employer, whether provided through a self-insured or a fully-insured policy with a third-party carrier.

2.12 "*Disability Insurance Account*" means an Account established for a Participant under the Plan for payment of Disability Insurance premiums.

2.13 "*Effective Date*" means the day the Plan begins as stated in the Plan Highlights.

2.14 "*Employee*" means any person who performs services for the Employer as a common law employee and receives compensation for those services other than a pension, retirement allowance, retainer, or fee under contract. Persons who act only as directors are not Employees. Persons providing services to the Employer through temporary agencies, leasing organizations, or independent contractor arrangements are not Employees eligible to participate in the Plan, even though they subsequently may be classified as employees of the Employer for employment tax, unemployment insurance, or other purposes by a government agency or a court.

2.15 "*Employer*" means the Employer as identified in the Plan Highlights. Employer also means any related or successor employer assuming the obligations created in this Plan, as identified in the Plan Highlights.

2.16 "*ERISA*" means the Employee Retirement Income Security Act of 1974, as amended, and corresponding provisions of future laws. Notwithstanding any other term or provision of the Plan Document, the Summary Plan Description, or the Plan Highlights, the provisions of ERISA shall apply only to the extent that the statute so requires.

2.17 "*Health Insurance*" means any written policy or program of group medical insurance coverage maintained by the Employer, whether provided through a self-insured or a fully-insured policy with a third-party carrier.

2.18 "*Health Insurance Account*" means an Account established for a Participant under the Plan for payment of Health Insurance premiums.

2.19 "*Health Savings Account*" or "*HSA*" means an Internal Revenue Code Section 223 Account under which a Participant is covered, which is used to pay medical expenses eligible under the HSA. Such Accounts are established and maintained outside of the Plan with an HSA trustee/custodian.

2.20 "*High Deductible Health Coverage*" means coverage under a group term health plan maintained under a separate plan, program, insurance policy or contract and which: (i) satisfies the requirements of Sections 105 and 106 of the Code; and (ii) qualifies as a high deductible health plan as described in Section 223 of the Code and regulations and guidance issued thereunder.

2.21 "*Highly Compensated Employee*" means any Employee whose income or ownership percentage exceeds the limits defined in Section 125(e) of the Code with respect to overall participation in this Plan, Section 105(h)(5) of the Code with respect to the Medical Flexible Spending Account, and Health Savings Account; Section 414(q) of the Code with respect to the Adoption Assistance Flexible Spending Account and the Dependent Care Flexible Spending Account.

2.22 "*Insurance Benefits*" means the benefits indicated in the Plan Highlights to which a Participant or that Participant's beneficiaries may be entitled (may include Dental, Disability, Health, Life and/or Vision Insurance).

2.23 "*Key Employee*" means any Employee who: (i) is an officer or owner of the Employer; and (ii) has annual compensation and/or ownership of the Employer as set forth in Section 416(i)(1) of the Code.

2.24 "*Life Insurance*" means any written policy or program of group term life insurance coverage (including accidental death and dismemberment coverage) maintained by the Employer, whether provided through a self-insured or a fully-insured policy with a third-party carrier.

2.25 "*Life Insurance Account*" means an Account established for a Participant under the Plan for payment of Life Insurance premiums.

2.26 "*Medical Expense*" means an expense for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Medical Expenses may include obstetrical expenses, expenses for therapy, hospital services, nursing services, medical, laboratory, surgical, dental and other diagnostic and healing services, x-rays, prescribed drugs and medicines, artificial teeth or limbs, ambulance hire, transportation primarily for and essential to medical care, and all other expenses that are considered to be for medical care as that term is defined in Sections 105(b) and 213(d) of the Code and Treasury Regulations and/or other Internal Revenue Service Guidelines issued thereunder. Insurance premiums are not eligible for reimbursement from a Medical Flexible Spending Account.

2.27 "*Medical Flexible Spending Account*" means an Account established for a Participant under the Plan for reimbursement of eligible Medical Expenses for services provided to the Participant, the Participant's Spouse or the Participant's Dependent.

2.28 *"Medical FSA Rollover"* means an amount not to exceed 20% of the maximum salary reduction amount under Code section 125(i) for that Plan Year that is treated as contributed to a Medical Flexible Spending Account (FSA) in the Plan Year, but is unused at the end of the Plan Year and is allowed to rollover into the next Plan Year.

2.29 "*Minimum Annual Deductible Amount*" means the minimum annual deductible amount applicable to a participant under a high deductible health plan, as determined under Section 223 of the Code and regulations and guidance issued thereunder.

2.30 "*Participant*" means an Employee who meets the requirements for participation specified in Section 3.

2.31 "*Plan*" means the Flexible Benefit Plan set forth in this document and the accompanying Plan Highlights, as amended from time to time.

2.32 "*Plan Administrator*" means the person, entity, or committee identified as such in the Plan Highlights and as described in Section 6.

2.33 "*Plan Highlights*" means the accompanying document, which the Employer completes adopting certain provisions and outlining Employer-specific customizations as part of the Plan.

2.34 "*Plan Year*" means the period beginning and ending on the dates specified as the Plan Year in the Plan Highlights, and every twelve consecutive month period thereafter.

2.35 "*Qualified Benefit*" means one or more of the following benefits permitted under Section 125 of the Code and offered through the Plan (as specified in the Plan Highlights): (i) payment of Dental Insurance premiums; (ii) payment of Disability Insurance premiums; (iii) payment of Health Insurance premiums; (iv) payment of Life Insurance premiums; (v) payment of Vision Insurance premiums; (vi) reimbursement of Adoption Expenses, but only to the extent not otherwise reimbursable; (vii) reimbursement of Dependent Care Expenses, but only to the extent not otherwise reimbursable; (viii) reimbursement of Medical Expenses, but only to the extent not otherwise reimbursable; and (ix) Health Savings Account contributions.

2.36 "*Qualifying Individual*" means a qualifying individual as defined for purposes of Section 21(b) of the Code.

2.37 "*Qualified Reservist Distribution*" means a distribution of the unused contributions to a Medical Flexible Spending Account under Section 125(h) of the Code to a reservist (as defined in 37 U.S.C. § 101) ordered or called to active duty as provided in Section 4.14. Qualified Reservist Distributions shall only be allowed if the Employer has elected to permit such distributions as specified in the Plan Highlights.

2.38 "*Salary Conversion Amount*" means the portion of a Participant's compensation that the Participant contributes to his or her Account(s) for the Plan Year and for purposes of Sections 4.6, 4.7 and 4.9.1, such amount also includes the Benefit Credit, if any, described in Section 4.1 that is credited to a Participant's Account(s).

2.39 "*Service Provider*" means Benefit Resource, LLC. and its authorized agents.

2.40 "*Spouse*" for purposes of any Qualified Benefit listed in Section 2.35 means a Participant's legal Spouse if recognized by State and Federal law.

2.41 "*Statutory Leave*" means an unpaid leave of absence under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act.

2.42 "*Vision Insurance*" means any written policy or program of group vision insurance coverage maintained by the Employer, whether provided through a self-insured or a fully-insured policy with a third-party carrier.

2.43 "*Vision Insurance Account*" means an Account established for a Participant under the Plan for payment of Vision Insurance premiums.

3. PARTICIPATION

3.1 *Eligibility Requirements*. An Employee who meets the eligibility requirements specified in the Plan Highlights shall be eligible to participate in the Plan except for the following restrictions:

- S Corp: Shareholders who are Employees and own more than 2% of the stock cannot participate. An Employee who is the Spouse, child, parent or grandparent of a more than 2% owner cannot participate. An individual who is a more than 2% shareholder at any time during the course of a Subchapter S corporation's taxable year is treated as a more than 2% shareholder for the entire year.
- Partnership: Partners cannot participate. An Employee who is the Spouse, child or parent of a partner can participate, if eligible.
- Sole Proprietorship: Sole proprietor cannot participate. An Employee who is the Spouse, child or parent of a sole proprietor can participate, if eligible.

3.2 *Participation Date*. An eligible Employee shall become a Participant in the Plan on the date specified in the Plan Highlights.

3.3 *Duration of Participation*. Except as otherwise provided in this Plan, an Employee shall continue as a Participant so long as he or she remains an Employee and/or has elected COBRA continuation coverage, and continues to meet the eligibility requirements of Section 3.1.

If the Plan Administrator reasonably believes that a Participant knowingly has submitted an expense which is not eligible, the Plan Administrator may immediately discontinue the Participant's participation in the Plan and prohibit the Participant from again participating in the Plan. The Plan Administrator may request from the Participant any information reasonably necessary to assist in such determination. Failure of the Participant to provide such information shall be cause for the Plan Administrator to find that the Participant knowingly submitted an expense that is not eligible.

3.4 *Reinstatement of Former Participant*. Subject to Sections 5.3.13, 5.3.14 and 5.4, a Participant whose employment with the Employer terminates and then resumes shall become a Participant again if and when he or she meets the requirements of Sections 3.1 and 3.2.

3.5 *FMLA and USERRA Leaves of Absence.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's benefits on the same terms and conditions as if the Participant were still an active Employee. To the extent coverage is not required to be continued by the FMLA or USERRA, the Participant will be treated as having terminated participation, as described under Section 4.9, except to the extent coverage is permitted or required to continue under the terms of the Employer's leave of absence policies or constituent Insurance Benefit plans.

3.6 *Non-FMLA and USERRA Leaves of Absence*. If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation, as described under Section 4.9, except to the extent coverage is permitted or required to continue under the terms of the Employer's leave of absence policies or constituent Insurance Benefit plans.

4. BENEFITS

4.1 *Benefit Credit*. A Participant may receive a Benefit Credit which shall be allocated to his or her Account(s), provided that the Benefit Credit is subject to such amounts, limits, terms and conditions as are specified by the Employer. Unless otherwise set forth by the Employer, Employees who become eligible to participate in the Plan on a date other than the first day of the Plan Year shall be eligible to receive the Benefit Credit as specified by the Employer for that Plan Year, if any, reduced proportionately for each full or partial month (or any other period of time relevant in calculating the Benefit Credit) of the Plan Year during which the Employee was not eligible to participate in the Plan. If a Participant does not use the full value of his or her Benefit Credit when enrolling in the Plan and electing to receive Qualified Benefits for a Plan Year, all or part of the Participant's unused Benefit Credit shall be paid to that Participant as compensation and subject to such terms and conditions as specified by the Employer.

4.2 *Salary Conversion Option*. Each Participant may elect to receive full payment of compensation in cash or to contribute a portion of compensation to his or her Account(s) for Qualified Benefits.

4.3 *Maximum Salary Conversion Amount.* The total amount of compensation that a Participant may contribute to his or her Account(s) through salary reduction in any one Plan Year shall not exceed the total of (i) the Participant's cost for Dental, Disability, Health, Life and Vision Insurance premiums for the Plan Year. Salary reductions in the last month of the Plan Year may be used to pay accident and health insurance premiums for the first month of the following Plan Year; plus (ii) the maximum amount that may be contributed by the Participant to his or her Adoption Assistance Flexible Spending Account, Dependent Care Flexible Spending Account, Medical Flexible Spending Account and/or Health Savings Account (less the Participant's Benefit Credit, if any, described in Section 4.1 that is allocable to such Accounts).

4.4 *Credits to Accounts.* For each Participant, a separate Account shall be maintained for each elected benefit which may include one or more of the Qualified Benefits as indicated in the Plan Highlights. The Salary Conversion Amount designated by each Participant shall be credited through equal payroll deductions to his or her Account(s). The amount credited to each Account for each pay period shall be the portion of the Salary Conversion Amount designated for that Account divided by: (i) the number of pay periods in the Plan Year; or (ii) for an Employee who becomes a Participant during the Plan Year, the number of pay periods remaining in the Plan Year after that Employee becomes a Participant. If applicable, each pay period, a Participant's Account(s) will also be credited with a pro-rata portion of the Participant's Benefit Credit, described in Section 4.1, which is allocable to such Account(s).

4.5 *Payment or Reimbursement.* Reimbursement of eligible Adoption, Dependent Care and/or Medical Expenses will be made directly to Participants on the schedule specified in the Plan Highlights and shall reduce the amount credited to the Participant's Account(s). The Service Provider shall provide reimbursement forms so that Participants can request reimbursements from their Adoption, Dependent Care and/or Medical Flexible Spending Accounts and/or institute such other procedures for paying claims relating to those Accounts, that the Service Provider or Plan Administrator, in its sole discretion, deems appropriate. Requests for reimbursement shall be accompanied by a copy of the bill, explanation of benefits or other documentation from an independent third-party supporting the reimbursement and shall contain the Participant's signed statement that the Adoption, Dependent Care and/or Medical Expense is not eligible for reimbursement from any other source and has not been reimbursed from any other source, as well as such other information that the Service Provider or Plan Administrator deems appropriate.

4.5.1 Claims relating to a Participant's Medical Flexible Spending Account may be paid and processed using a prepaid card designed for such purpose ("Beniversal® Card"). The availability of the Participant's Medical Flexible Spending Account funds on the card is outlined in the Plan Highlights. The Service Provider or Plan Administrator, in its sole discretion, shall adopt procedures to ensure that amounts paid with the Beniversal Card qualify as eligible Medical Expenses under the Plan. Such procedures shall comply with the regulations under Section 125 of the Code and include:

- If the Beniversal Card is used to pay an expense that is electronically validated at the point-of-sale to be an eligible Medical Expense, no further action is required.

- If the Beniversal Card is used to pay an expense that is not electronically validated at the point-of-sale to be an eligible Medical Expense, the Participant must submit such itemized bills, receipts or other information requested by the Service Provider or Plan Administrator to verify that the amount was an eligible Medical Expense.

- If the Participant fails to provide information to satisfy the Service Provider or Plan Administrator that amounts paid via the Beniversal Card are eligible Medical Expenses, the Plan Administrator will take whatever action it deems appropriate to require the Participant to repay the amount that has not been verified, including: (i) requesting the Participant to reimburse the Plan the amount that has not been verified; (ii) suspending the Participant's access to Medical Expense funds; (iii) offsetting future medical reimbursement claims by the amount paid via the Beniversal Card that has not been verified; (iv) suspending the Participant's eligibility to participate in the Plan; and (v) deducting from the Participant's taxable wages the amount of the expense paid via the Beniversal Card that has not been verified.

The Service Provider or Plan Administrator, in its sole discretion, may adopt such other rules that it deems appropriate that will govern the use of a prepaid card product to pay eligible medical expenses (e.g., canceling the card upon the Participant's termination of employment, establishing transaction limits on the card, charging fees to use such cards, etc.). If the Service Provider or Plan Administrator's correction efforts prove unsuccessful, the Participant remains indebted to the Plan for the amount of the payment that has not been verified. In that event, and consistent with its business practices, the Employer may treat the amount that has not been verified as it would any other business indebtedness.

4.6 *Maximum Reimbursement Amounts.* In the case of reimbursement for Adoption Expenses, the Participant may receive up to the amount then credited to the Participant's Adoption Assistance Flexible Spending Account. In the case of reimbursement for Dependent Care Expenses, the Participant may receive up to the amount then credited to the Participant's Dependent Care Flexible Spending Account. In the case of reimbursement for Medical Expenses, the Participant may receive an amount equal to the Salary Conversion Amount designated for the Participant's

Medical Flexible Spending Account for the Plan Year less the amount of any prior reimbursement from that Medical Flexible Spending Account for Medical Expenses for services provided during the Plan Year plus any Medical FSA Rollover from the prior Plan Year (if allowed by the Plan).

4.7 *Forfeitability of Benefits for Flexible Spending Accounts*. No Participant shall be entitled to reimbursement for Adoption, Dependent Care and/or Medical FSA expenses provided in a prior Plan Year unless a claim for reimbursement is submitted within the timeframe specified in the Plan Highlights. Except as provided in Sections 4.7.1 and 4.7.2 below, if the Salary Conversion Amount for a Plan Year exceeds the Qualified Benefits for the Plan Year, the Plan Highlights indicates the disposition of the unused portion of the Participant's Salary Conversion Amount. With respect to any forfeitures, the Plan Administrator, in its sole and absolute discretion, may: (i) apply the forfeited amount to any reasonable administrative expenses of the Plan; (ii) distribute the forfeited amount to all Participants in the Plan on a uniform basis not related to the amount of their individual forfeitures; or (iii) where permitted by law, return the forfeited amount to the Employer.

4.7.1 *Grace Period*. If the Grace Period is adopted by the Employer in the Plan Highlights, Adoption, Dependent Care and/or Medical FSA expenses provided during the Grace Period for a Plan Year may be treated as provided during that Plan Year for purposes of this Section 4. To the extent the contributions made for that Plan Year for such Qualified Benefits have not already been used for, or are not required to pay, such Qualified Benefits actually provided during the Plan Year, the contributions shall be used to pay such Qualified Benefits provided during the Grace Period, in accordance with provisions of this Section 4, provided all requirements and conditions for such Qualified Benefit are satisfied.

- If the total contributions to a Participant's Account exceed such Qualified Benefits paid from that Account for the Plan Year, including such Qualified Benefits provided during the Grace Period for the Plan Year, the Participant shall forfeit the excess contributions.

- This Subsection 4.7.1 shall be interpreted and applied in a manner consistent with IRS Notice 2005-42 and Treasury Regulations or other guidance issued to reflect or supersede IRS Notice 2005-42.

4.7.2 *Medical FSA Rollover*. For Plan Years beginning on or after January 1, 2013, if the Employer elects to permit Medical FSA Rollovers for a Plan Year in the Plan Highlights, to the extent the contributions made to a Medical Flexible Spending Account are not used for a Plan Year, an amount not to exceed 20% of the maximum salary reduction amount under Code section 125(i) for that plan year of the unused contributions shall not be forfeited at the end of the Plan Year, but shall be carried over to the Participant's Medical Flexible Spending Account for the next Plan Year, subject to the following rules:

- If the total contributions to a Participant's Account plus the amount of any Medical FSA Rollover exceed Medical Expenses paid from the Account for the Plan Year, the Participant shall forfeit the excess contributions.

- The Employer may elect to adopt a Grace Period or a Medical FSA Rollover, but not both.

- This Subsection 4.7.2 shall be interpreted and applied in a manner consistent with IRS Notice 2013-71 and Treasury Regulations or other guidance issued to reflect or supersede IRS Notice 2013-71.

4.7.3 *Experience Gains for Flexible Spending Accounts*. Any amounts forfeited by Participants in accordance with this Section 4.7 may be, in the sole and absolute discretion of the Plan Administrator, used as follows:

- In the case of forfeitures from the Adoption Assistance Flexible Spending Account or Dependent Care Flexible Spending Account only, retained by the Employer;

- If not retained by the Employer, or in the case of any Account other than an Adoption Assistance Flexible Spending Account or Dependent Care Flexible Spending Account, may be used only in one or more of the following ways: (i) to reduce required salary reduction amounts for the immediately following Plan Year, on a reasonable and uniform basis, as described in Prop. Treas. Reg. Section 1.125-5(o)(2) (or successor regulations); (ii) returned to employees on a reasonable and uniform basis, as described in Prop. Treas. Reg. Section 1.125-5(o)(2) (or successor regulations); (iii) to defray expenses to administer the plan; or (iv) any other purpose permitted by Prop. Treas. Reg. Section 1.125-5(o) (or successor regulations).

4.8 *Cessation of Contributions*. A Participant who ceases to make the required contributions to an Account shall cease to be provided with that benefit on the date of the last contribution, and shall be prohibited from making a new benefit election for the remaining portion of the period of coverage unless the Participant experiences a qualifying election change event described in Section 5.3. However, if a Participant ceases contributions to his or her Adoption Assistance, Dependent Care or Medical Flexible Spending Account consistent with a change described in Section 5.3, that individual may continue to request reimbursement from that Account within the timeframe specified in the Plan Highlights. However, if contributions cease due to loss of eligibility, the rules in Section 4.9 will apply. Participants may make contributions to and claim benefits from a Health Savings Account outside of this Plan even if HSA Benefits contributions under this Plan cease, in accordance with the HSA governing documents and procedures determined by the HSA trustee/custodian.

4.9 *Loss of Eligibility (including Termination of Employment)*. Subject to Sections 5.3.13 and 5.3.14, claims for reimbursement of Adoption Expenses, Dependent Care Expenses and Medical Expenses for services provided after the loss of eligibility are controlled by the rules stated below. Reimbursement requests for eligible expenses must be submitted within the timeframe specified in the Plan Highlights.

4.9.1 A Participant who loses eligibility during the Plan Year may be eligible to elect, pursuant to this Section and Section 4.11, to continue a Medical Expense contribution election in effect through the end of the Plan Year by continuing to make contributions to that Medical Flexible Spending Account. A Participant making this election may request reimbursement for eligible Medical Expenses for services provided within the timeframe specified in the Plan Highlights. The amount available for reimbursement of Medical Expenses shall equal the Salary Conversion Amount designated for the Participant's Medical Flexible Spending Account for the Plan Year less the amount of any prior reimbursement from that Medical Flexible Spending Account during the Plan Year. A Participant who does not make this election may request reimbursement only for those eligible Medical Expenses for services provided prior to the loss of eligibility. Such request for reimbursement must be submitted within the timeframe specified in the Plan Highlights and, at the end of this run-out period, the Participant shall forfeit any amount remaining in his or her Medical Flexible Spending Account.

4.9.2 A Participant who loses eligibility during the Plan Year may request reimbursement for any eligible Adoption Expenses or Dependent Care Expenses for services provided through the end of the Plan Year during which he or she was a Participant. As stated in Section 4.6 above, the amount available for reimbursement of Adoption Expenses or Dependent Care Expenses shall be limited to the amount then credited to the Adoption Assistance Flexible Spending Account or Dependent Care Flexible Spending Account.

4.9.3 A Participant who loses eligibility to make contributions to the HSA for reasons other than termination of employment will still have access to HSA funds, including use of the

Beniversal Card for HSA to pay for Medical Expenses.

4.9.4 A Participant who loses eligibility to make contributions to the HSA because of termination of employment will have their HSA transferred to the trustee/custodian for administration. The trustee/custodian will contact the Participant directly regarding the HSA.

4.10 *Coordination of Medical Flexible Spending Account Benefits*. Medical Flexible Spending Account benefits under this Plan are intended to pay for Medical Expenses not previously reimbursed or reimbursable elsewhere through insurance or otherwise. Accordingly, the Medical Flexible Spending Account shall not be considered to be a group health plan for coordination of benefits purposes, and Medical Flexible Spending Account benefits shall not be taken into account when determining benefits payable under any other plan. If only a portion of a Medical Expense has been reimbursed elsewhere (e.g. because the health insurance plan imposes co-payment or deductible limitations), then the remaining portion of such Medical Expenses can be reimbursed from a Participant's Medical Flexible Spending Account if it otherwise meets the requirements for reimbursement under this Plan. If a Participant receives benefits under the Plan and is subsequently reimbursed for the expenses from any other source at any time, the Participant shall remit those benefits to the Employer to the extent of the reimbursement. If an Employer sponsors both a Health Reimbursement Account Plan and a Medical Flexible Spending Account under this Plan, then reimbursements shall be made first from the Medical Flexible Spending Account, unless otherwise specified in the Plan Highlights or under the coordination of benefits provisions of the Employer's Health Reimbursement Account Plan.

4.11 *COBRA Health Continuation Coverage*. The Employer shall advise each Participant of any rights he or she may have to continued Dental, Health and/or Vision Insurance coverage and continued reimbursement from the Participant's Medical Flexible Spending Account pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). To the extent permitted by Section 125 of the Code and regulations thereunder, Employees may remain Plan Participants during the COBRA continuation period.

4.12 *Insurance Benefits*. Any Insurance Benefits payable to Participants are described in the respective plan documents and summary plan descriptions (SPDs), and in the case of fully-insured benefits, in the contracts or policies issued by the insurance companies.

4.12.1 The Plan provides only for payment of insurance premiums. The actual Insurance Benefits to which a Participant or the Participant's beneficiaries may be entitled are separately and exclusively governed by the applicable plan documents, SPDs, contracts or policies.

4.12.2 The Employer does not guarantee payment of Insurance Benefits, and eligibility under the Plan does not guarantee that Participants will satisfy any requirements for coverage under the terms of the respective Insurance Benefit plan.

4.12.3 Current insurance premium costs and/or the Employer's share thereof shall be provided to eligible Employees before the beginning of each Plan Year. If premium costs change during the Plan Year, a revised schedule of insurance premium costs shall be distributed.

4.13 *Statement of Benefits*. The Plan Administrator shall provide by January 31 of each year, in the form provided under the Code, a statement to all Participants showing the Participant's contributions to his or her Adoption Assistance Flexible Spending Account, Dependent Care Flexible Spending Account and Health Savings Account for the previous calendar year.

4.14 *Qualified Reservist Distributions*. Notwithstanding any other provision of the Plan to the contrary, if the Employer permits Qualified Reservist Distributions as indicated in the Plan Highlights, a Participant who meets each of the following requirements may elect to receive a distribution of certain funds from his or her Medical Flexible Spending Account for a Plan Year:

4.14.1 The Participant's contributions to his or her Medical Flexible Spending Account for the Plan Year as of the date of the request for a Qualified Reservist Distribution exceed the reimbursements received from the Medical Flexible Spending Account for the Plan Year as of that date.

4.14.2 The Participant is ordered or called to active military duty for a period of at least one hundred eighty (180) days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

4.14.3 The Participant has provided the Plan Administrator with a copy of the order or call to active duty. An order or call to active duty of less than one hundred eighty (180) days' duration must be supplemented by subsequent calls or orders to reach a total of one hundred eighty (180) or more days.

4.14.4 During the period beginning on the date of the order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant delivers a written election to the Plan Administrator in such form as the Plan Administrator may prescribe, requesting a Qualified Reservist Distribution.

4.14.5 The Plan Administrator will review all requests for Qualified Reservist Distributions on a uniform and consistent basis. Requests for Qualified Reservist Distributions that are approved by the Plan Administrator shall be paid within a reasonable time, not to exceed sixty (60) days after the date of the Participant's request.

4.14.6 The amount of any Qualified Reservist Distribution made under this provision shall be equal to the Participant's contributions to his or her Medical Flexible Spending Account for the Plan Year as of the date of the request for a Qualified Reservist Distribution, minus the reimbursements received from the Medical Flexible Spending Account for the Plan Year as of that date. 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 provided. Any portion of the distribution that is not a reimbursement for verified Medical Expenses will be included in the Participant's gross income and wages.

4.14.7 A Participant who has requested a Qualified Reservist Distribution shall forfeit the right to receive reimbursements for Medical Expenses provided during the Plan Year and on or after the date of the distribution request. However, such a Participant may claim reimbursement for Medical Expenses provided during the Plan Year (or other period of coverage, if applicable) and before the date of the distribution request, even if such claims are submitted after the date of the distribution, so long as the total dollar amount of such claims does not exceed the amount of the Participant's contribution election under the Medical Flexible Spending Account for the Plan Year, less the sum of the Qualified Reservist Distribution under this provision and the reimbursements received from the Medical Flexible Spending Account for the Plan Year.

4.15 *Health Savings Account Benefits*.

4.15.1 For the purposes of this Section, the following terms have the following meanings:

- *"HSA Benefits"* means contributions made to a Health Savings Account on tax-free salary reduction basis under this Plan.

- *"General Health FSA"* means a General Medical Flexible Spending Account under this Plan or under such an account under any other employer's plan.

- *"Limited FSA"* means a Limited Medical Flexible Spending Account under this Plan or such an account under any other employer's plan (e.g., a limited-purpose or post-deductible flexible spending account under another employer's plan where coverage is limited to only vision, dental and/or post-deductible medical expenses, as described in Revenue Ruling 2004-45).

- *"General HRA"* means a General Health Reimbursement Account pursuant to IRS Notice 2002-45 established outside this Plan for reimbursement of eligible medical expenses.

- *"Limited HRA"* means a Limited Health Reimbursement Account pursuant to IRS Notice 2002-45 established outside this Plan for reimbursement of eligible medical expenses, where coverage is limited to only vision, dental and/or post-deductible medical expenses, as described in Revenue Ruling 2004-45.

- *"Trustee/Custodian"* is the financial institution responsible for holding and managing the assets in the HSA. The trustee/custodian is chosen by the Service Provider,

4.15.2 Eligible Employees may elect HSA Benefits only if the Employee is covered by High Deductible Health Coverage, meets other criteria for participation in an HSA outlined in Section 223 of the Code, and is enrolled in the HSA described in the Plan Highlights.

4.15.3 To the extent allowed by the IRS, the Employer may contribute to a Participant's HSA under the Plan.

4.15.4 As provided in Section 5.3.15, Participants may prospectively change or revoke salary reduction elections for HSA Benefits at any time, so long as the election is made by any applicable administrative processing deadline imposed by the Employer, Plan Administrator, or Service Provider.

4.15.5 If an Employee participates in a General Health FSA or General HRA, then the Participant cannot elect HSA Benefits at any time during the General Health FSA or General HRA coverage period, even if the General Health FSA or General HRA balance is reduced to $0 prior to the end of the coverage period. These restrictions do not apply to a Limited FSA or Limited HRA. In addition, if an Employee is a beneficiary under a General Health FSA or General HRA, such as if the Employee's Spouse participates in a General Health FSA or General HRA and the Employee's medical expenses are eligible for reimbursement from the Spouse's General Health FSA or General HRA, then the Employee cannot elect HSA Benefits at any time during the General Health FSA or General HRA coverage period, even if the General Health FSA or General HRA balance is reduced to $0 prior to the end of the coverage period.

4.15.6 An Employee who is a Participant or beneficiary in a General Health FSA cannot elect HSA Benefits for any of the first three calendar months following the close of the General Health FSA plan year if the General Health FSA provides a grace period under Prop. Treas. Reg. Section 1.125-1(e) or successor regulations. However, the Participant can elect HSA Benefits immediately following the close of the General Health FSA Plan Year despite any grace period if the account balance in the General Health FSA was $0 at the close of the General Health FSA Plan Year. An Employee who is a Participant or beneficiary in a General Health FSA cannot elect HSA Benefits for the next Plan Year if the General Health FSA provides a Medical FSA Rollover into the General Health FSA for the next Plan Year. However, the Participant can elect HSA Benefits immediately following the close of the General Health FSA Plan Year despite any Medical FSA Rollover if the Participant declines or waives the Medical FSA Rollover before the close of the General Health FSA Plan Year or has the Medical FSA Rollover carried into an HSA compatible health FSA instead of the General Health FSA.

4.15.7 An Employee who is a Participant or beneficiary in a General HRA may elect HSA Benefits under this Plan following the close of the General HRA Plan Year if the General HRA

balance is $0 at the close of the General HRA Plan Year, and the Participant or other account holder (as applicable) waives participation in the General HRA for the following HRA Plan Year prior to the beginning of that Plan Year (assuming waiver is permitted by the applicable General HRA plan). Alternatively, even if the General HRA balance is greater than $0 at the end of the General HRA Plan Year, a Participant may elect HSA Benefits under this Plan following the close of the Plan Year if the Participant or other account holder (as applicable) elects to suspend participation in the General HRA for the following Plan Year, prior to the beginning of that Plan Year (assuming suspension is permitted by the applicable HRA plan).

4.15.8 The annual contribution to a Participant's HSA cannot exceed the limits described in Section 223 of the Code and applicable Department of Treasury and/or IRS regulations and guidance. In no event shall the amount elected for HSA Benefits under this Plan exceed the statutory maximum amount for HSA contributions corresponding with the Participant's High Deductible Health Coverage option for the calendar year in which the contribution is made. An additional catch-up contribution may be made by Participants who are age 55 or older.

In addition, the HSA Benefits maximum annual contribution shall be:

- reduced by any matching (or other) contribution made by the Employer on the Participant's behalf (other than HSA Benefits) made under the Plan, if any; and

- prorated for the number of months in which the Participant is an eligible Employee for HSA Benefits purposes.

4.15.9 HSA Benefits under this Plan consist solely of the ability to make contributions to the HSA on a tax-free salary reduction basis and for the Employer to make contributions to a Participant's HSA, if any.

4.15.10 An HSA is designed to pay for any eligible Medical Expenses for the Participant, Participant's Spouse or Participant's Eligible Dependents. This includes expenses paid toward deductibles, co-insurance, dental, vision, and chiropractic services provided *after* the HSA has been established. An HSA is considered established on the first date that the Participant is eligible to contribute to the Account.

4.15.11 Withdrawals from the HSA are limited to the balance in the Account. Funds for eligible Medical Expenses can be accessed by using the Beniversal Card for HSA at qualified merchants. Participants can also access funds in the HSA by using the bill payment service to pay a provider directly or they can reimburse themselves for out-of-pocket expenses by transferring funds from the HSA to a personal checking or savings account. It is the responsibility of the Participant to maintain all receipts for tax reporting and potential audit purposes. Funds used for ineligible expenses are subject to any applicable taxes and penalties.

4.15.12 The HSA is an Account that is established and maintained by an HSA trustee/custodian chosen by the Service Provider outside this Plan to be used primarily for the payment of eligible Medical Expenses as set forth in Section 223(d)(2) of the Code. The Employer has no authority or control over the funds deposited in an HSA. Even though this Plan may allow tax-free salary reduction contributions to an HSA in the form of HSA Benefits, and the Employer may elect to contribute to a Participant's HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. 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 is not a part of this Plan.

The Service Provider will maintain records to keep track of the HSA contributions a Participant makes via tax-free salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

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

5. ELECTION PROCEDURES

5.1 *Annual Elections.* Prior to the beginning of each Plan Year, the Plan Administrator shall provide each Employee eligible to participate in the Plan that Plan Year with election procedures. Employees who become eligible to participate in the Plan during the Plan Year shall be provided with election procedures once they meet the eligibility requirements for participation. Each Employee shall elect the amount of compensation that will be reduced automatically on a tax-free basis and contributed to the Employee's Account(s) to pay premiums for Dental, Disability, Health, Life and/or Vision Insurance (as indicated in the Plan Highlights), unless the Participant elects to pay for the premiums on an after-tax basis. Each Participant will need to specify the Salary Conversion Amount for the Plan Year, and the portion of those amounts to be credited to the Participant's Adoption Assistance Flexible Spending Account, Dependent Care Flexible Spending Account, Medical Flexible Spending Account and/or Health Savings Account. Elections must be completed and submitted on or before the date specified by the Plan Administrator. A Participant's failure to submit an election by the specified date shall be deemed an election not to make any contributions to an Adoption, Dependent Care, or Medical Flexible Spending Accounts or a Health Savings Account for the Plan Year. If the waiting period for eligibility for a new hire is less than thirty (30) days after the date of hire, then Employer may allow the Employee to submit an election within thirty (30) days after the date of hire with elections retroactive to the date of hire. Employees who terminate employment and resumes employment are subject to Section 5.4.

5.2 *Irrevocability of Elections*. Once an election is made for a Plan Year and the Plan Year commences, the election shall be irrevocable for the entire Plan Year, except as provided in Section 5.3.

5.3 *Permissible Changes of Elections*. Participants may revoke their contribution elections and make new elections during a Plan Year in accordance with the provisions of this Section. Any change in elections made during a Plan Year must be appropriate and necessary as a result of the events that qualify for the change. The Participant must submit the election change request to the Employer within the timeframe required by the Employer. If no timeframe is specified by the Employer, then the timeframe shall be thirty (30) days, except where a different time period is required by this Plan, a constituent Insurance Benefit plan, or by Section 125 of the Code and regulations thereunder. Participants cannot reduce elections for their Adoption Assistance Flexible Spending Account, Dependent Care Flexible Spending Account, and/or Medical Flexible Spending Account to the point where contributions for the Plan Year are less than the amount already reimbursable for that Plan Year. Election changes shall be effective at the earliest date permitted by Section 125 of the Code and regulations thereunder, unless a later date is specified by the Employer and/or the constituent Insurance Benefit plan. This Section shall be interpreted in a manner consistent with Section 125 of the Code and other guidance issued thereunder.

5.3.1 *Change in Status*. If eligibility for coverage changes, a Participant's contributions may change on account of and in a manner consistent with: (i) a change in the employment status of the Participant, the Participant's Spouse or the Participant's Dependents resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes the Participant, the Participant's Spouse or the Participant's Dependents to become or cease to be eligible for coverage under this Plan or other employer plan providing Qualified Benefits; (ii) a change in the Participant's legal marital status, (including marriage, divorce, death of a Spouse, legal

separation, or annulment); (iii) a change in the place of residence of the Participant, the Participant's Spouse or the Participant's Dependents; (iv) a change in a Dependent's eligibility for coverage due to age, student status, marriage or similar circumstance, or, for a Dependent Care Flexible Spending Account, a change in the status of an individual as a Qualifying Individual; (v) a change in the number of Dependents (including a change resulting from a birth, death, adoption or placement for adoption of a child); or (vi) any other change considered to be a change in status under Section 125 of the Code and regulations thereunder.

5.3.2 *Change in Cost*. If the Participant's cost for Dental, Disability, Health, Life or Vision Insurance coverage changes, there shall be an automatic corresponding change to their Dental, Disability, Health, Life or Vision Insurance contributions; provided, however, if there is a significant increase in cost of a Dental, Disability, Health, Life or Vision Insurance coverage option, an affected Participant may revoke the election of that coverage and may elect another option providing similar coverage (if available) with a corresponding change to contributions, or drop coverage if no other benefit package option providing similar coverage is available.

If there is a change in a Participant's dependent care provider or in the dependent care provider's cost for services, the Participant may make a corresponding change to Dependent Care Account contributions; provided that in the case of a change in a dependent care provider's cost for services the dependent care provider is not a relative of the Participant within the meaning of Sections 152(a)(1) through (8) of the Code, incorporating rules of Sections 152(a)(1) and (2) of the Code.

5.3.3 *Significant Curtailment or Cessation of Coverage*. If there is a significant curtailment in or cessation of a Participant's Dental, Disability, Health, Life or Vision Insurance coverage (including elimination of that coverage option), or Dependent Care, and such curtailment or cessation constitutes reduced coverage for Participants generally, an affected Participant may: (i) revoke the election of that coverage and may elect another option providing similar coverage (if available) with a corresponding change to Dental, Disability, Health, Life or Vision Insurance or Dependent Care Account contributions; or (ii) drop coverage if no similar benefit option is available.

5.3.4 *Significant Improvement in or Addition of Coverage*. If a Dental, Dependent Care, Disability, Health, Life or Vision Insurance coverage option is added or significantly improved, the Dental, Disability, Health, Life or Vision Insurance or Dependent Care Account contributions of a Participant who elects the new or improved coverage option shall be changed to correspond to the cost of the coverage.

5.3.5 *Change in Coverage under other Employer's Plan*. A Participant may change contributions (other than Medical Flexible Spending Account contributions) under this Plan in a manner consistent with a change by the Participant's Spouse, former Spouse or Dependent under another Qualified Benefits plan if the change under such other plan: (i) is permitted under other events listed in Sections 5.3; or (ii) is made for the normal election period under such other plan and that period is different from the Plan Year of this Plan.

5.3.6 *Loss of coverage under Governmental or Educational Group Health Plan.* A Participant may change contributions to add similar coverage under this Plan for the Participant, the Participant's Spouse or the Participant's Dependents if that individual loses Dental, Health or Vision coverage under any group coverage sponsored by a governmental or educational institution.

5.3.7 *Purchase of Coverage Through a Marketplace (Exchange)*. A Participant may revoke contributions to the Health Insurance Account under this Plan when the Participant is eligible for a special enrollment period to enroll in a qualified health plan through a Marketplace, as established by the Affordable Care Act (ACA); or the Participant seeks to enroll in a qualified

health plan through a Marketplace during the Marketplace's annual enrollment period. The revocation of the Health Insurance Account contributions corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, into a qualified health plan through a Marketplace. The new coverage must be effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

5.3.8 *Health Plan Special Enrollment Rights*. A Participant's Health Insurance Account contributions may be changed in a manner and within a timeframe consistent with the exercise of special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This special rule also applies to a Participant's Dental and Vision Insurance Account contributions and Medical Flexible Spending Account contributions to the extent the Participant's Dental and Vision Insurance Benefits and Medical Flexible Spending Account are subject to special enrollment rights under HIPAA.

5.3.9 *COBRA Coverage*. If a Participant, the Participant's Spouse or the Participant's Dependents become eligible for continuation coverage under the Consolidated Omnibus Reconciliation Act of 1985 (or similar State law), the Participant may increase the Dental, Health and Vision Insurance Account contributions to pay for the coverage.

5.3.10 *Court Judgment, Decree or Order*. A Participant's Dental, Health or Vision Insurance Account contributions may be increased to pay for a Dependent child's or foster child's Dental, Health or Vision Insurance as required under a court judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody including a Qualified Medical Child Support Order (QMCSO) as defined under Section 609 of ERISA. Similarly, such contributions may be reduced to reflect any decrease in the Dental, Health or Vision Insurance cost if such judgment, decree or order requires someone else to provide health coverage for such child. To the extent permitted under Section 125 of the Code, a Participant's Medical Flexible Spending Account contributions may also be increased or reduced in a manner consistent with such court judgment, decree or order.

5.3.11 *Entitlement to Medicare or Medicaid*. A Participant's Health Insurance Account contributions may be reduced if the Participant, the Participant's Spouse or the Participant's Dependents become entitled to Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines), and may be increased if the Participant, the Participant's Spouse or the Participant's Dependents lose such Medicare or Medicaid eligibility. To the extent permitted under Section 125 of the Code, a Participant's Dental and Vision Insurance contributions and Medical Flexible Spending Account contributions may also be reduced or increased when the Participant, the Participant's Spouse or the Participant's Dependents become entitled to, or lose, such Medicare or Medicaid eligibility.

5.3.12 *Reduction in Hours of Service*. Participants may revoke contribution elections under this Plan to the Health Insurance Account whose hours of service was reduced to average less than thirty (30) hours of service per week so long as the reduction does not affect the eligibility for coverage under the Employer maintained Health Insurance. The revocation of the contributions to the Health Insurance Account corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another health plan that provides minimum essential coverage as required by the Affordable Care Act (ACA). The new coverage must be effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

5.3.13 *Special Rule for Statutory Leave.* If a Participant takes a Statutory Leave, the Participant may: (i) revoke the elections at the beginning of the Statutory Leave and make new elections at the end of the Statutory Leave; or (ii) keep the elections in place by prepaying contributions through tax-free payroll deductions before the beginning of the Statutory Leave or continuing to pay contributions through after-tax contributions during the Statutory Leave; provided, however,

if the Statutory Leave spans two Plan Years, the Participant may not prepay contributions due after the last day of the Plan Year in which the Statutory Leave begins. A Participant shall not be eligible for reimbursement from the Dependent Care or Medical Flexible Spending Account during a period in which contributions cease as a result of a Statutory Leave. Notwithstanding the above, the Employer may elect to pay a Participant's contributions during a Statutory Leave and recover the Participant's share of the cost of these payments through tax-free payroll deductions after the Statutory Leave if the Employer does so for all Participants in the case of a Statutory Leave or non-statutory unpaid leave.

5.3.14 *Special Rule for Adoption Assistance*. Participants may prospectively change or revoke salary reduction elections for an Adoption Assistance Flexible Spending Account in the event of the commencement or termination of an adoption proceeding. This is the only qualifying event that would permit an election change with respect to an Adoption Assistance Flexible Spending Account.

5.3.15 *Prospective Changes to Health Savings Account Contributions Allowed at any Time*. Participants may prospectively change or revoke salary reduction elections for Health Savings Account contributions at any time, so long as the election is made by any applicable administrative processing deadline imposed by the Employer, Service Provider or Plan Administrator.

5.3.16 *Family Glitch Act Changes*. Effective January 1, 2023, a Participant may revoke prospectively an election of family coverage under the Plan with respect to coverage that provides minimum essential coverage; provided the following conditions are satisfied: (i) one or more related covered individuals are eligible for a special enrollment period to enroll in a Qualified Health Plan (QHP) through an Exchange, or one or more related covered individuals seeks to enroll in a QHP during the Exchange's annual open enrollment period; and (ii) the revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the related individual or related individuals in a QHP through an Exchange for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked. If the Participant does not enroll in a QHP through an Exchange, the Participant must elect self-only coverage (or family coverage including one or more already-covered related individuals) under the group health plan. The Plan may rely on the reasonable representation of a Participant that the Participant and/or related individuals have enrolled or intend to enroll in a QHP through an Exchange for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked. This change only affects the Participant's election under the Participant's Health Insurance Account.

5.4 *Termination of Employment.* Notwithstanding Section 5.3.1, but subject to Sections 5.3.13 and 5.3.14, if a Participant's employment with the Employer terminates and then resumes in the same Plan Year within a period of thirty (30) days or less, that individual's elections in effect before termination shall automatically be reinstated upon resumption of employment, unless some other intervening event has occurred that would permit a change in election(s). This does not apply to Health Savings Accounts as subject to Section 5.3.15.

5.5 *Nondiscrimination Requirements.* The Plan Administrator may in its sole and absolute discretion take any actions that it deems appropriate to assure compliance with all applicable nondiscrimination requirements and all applicable limitations on Qualified Benefits provided to Key Employees or Highly Compensated Employees. These actions may include without limitation the modification of elections by Key Employees and Highly Compensated Employees with or without their consent. If at any time during the Plan Year the Plan Administrator determines that Dependent Care Flexible Spending Account contributions by Highly Compensated Employees will cause the Plan to fail the average benefits test of Section 129(d)(8) of the Code, the Plan Administrator shall take such actions it deems appropriate, which may

include, without limitation, reducing pro rata or terminating such contributions, as necessary, to satisfy the test.

6. PLAN ADMINISTRATION

6.1 *Plan Administrator.* The Employer may appoint a person or committee of persons to act as Plan Administrator and may remove the Plan Administrator from office at any time. Any such appointment or removal shall be in writing. If no appointment is made, the Employer shall be the Plan Administrator.

6.2 *Powers.* The Plan Administrator has full discretionary authority and responsibility to control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan (but not to modify or amend the Plan) and to decide any and all questions arising in the administration, interpretation, and application of the Plan. The Plan Administrator shall establish whatever rules it finds necessary for the operation and administration of the Plan and shall endeavor to apply such rules in its decisions so as not to discriminate in favor of any person. The decisions of The Plan Administrator or its action with respect to the Plan shall be conclusive and binding upon the Employer and all persons having or claiming to have any right or interest in or under the Plan, except to the extent the Plan Administrator's decision is subject to review by a court of law.

6.3 *The Committee*. If the Employer designates a committee of persons (the "Committee") to serve as the Plan Administrator, the members of the Committee may elect from their number a chairman, who needs not be an Employee, and may appoint a secretary, who needs not be an Employee or a member of the Committee. They may appoint from their number such subcommittees with such powers as they shall determine. They may allocate responsibility among themselves or delegate any of their duties or responsibilities to other persons in accordance with this Section 6. A member of the Committee may resign at any time by delivering a written resignation to the Employer.

The Committee may hold meetings upon such notice, at such place or places, and at such time or times as they may determine. A majority of the members of the Committee shall constitute a quorum for the transaction of business. All resolutions or other actions taken by the Committee shall be by vote of a majority of those present at a meeting of the Committee at which a quorum shall be present or, if they act without a meeting, in writing by all the members of the Committee.

6.4 *Delegation of Responsibilities*. The Plan Administrator may delegate any of its duties or responsibilities to other persons, including the Employer or any of its officers or Employees. Any such allocation or delegation of responsibilities shall be by an instrument in writing, setting forth specifically the delegated duties, signed by or on behalf of the Plan Administrator and the delegated person and shall be exercised in a reasonable manner taking into account the discretionary or ministerial nature of the responsibility allocated or delegated and the capabilities of such person or persons to whom the responsibility is allocated or delegated.

6.5 *Third-Party Contracts*. The Plan Administrator or any person or persons to whom the Plan Administrator has delegated responsibilities may employ, with the approval of the Plan Administrator, one or more accountants, actuaries, legal counsel or other persons as shall be deemed necessary for the effective control and management of the operation and administration of the Plan. The Plan Administrator, the Employer and its officers and directors, and any person to whom any duty or responsibility has been delegated by the Plan Administrator shall be entitled to rely upon all tables, valuations, certificates, opinions and reports furnished by any duly appointed accountant, actuary, legal counsel or other person and shall be fully protected in respect of any action taken or permitted by them in good faith in reliance upon any such tables, valuations, certificates, reports or opinions.

6.6 *Expenses.* The Plan Administrator shall not receive any compensation from the Plan for its services, but the Employer may pay the Plan Administrator a salary and the Plan may reimburse the Plan Administrator for any necessary expenses incurred.

6.7 *Records.* The Plan Administrator shall maintain records showing the fiscal transactions of the Plan.

6.8 *Indemnification.* To the extent not covered by insurance and to the fullest extent permitted by law and the Employer's governing rules, each person who is or has been the Plan Administrator, including each person who is or has been a member of the Committee, if applicable, or any officer or Employee of the Employer who has been delegated responsibilities by the Plan Administrator, shall be indemnified by the Employer against expenses (including amounts paid in settlement with the approval of the Employer) reasonably incurred by him or her in connection with any action, suit, or proceeding to which he or she may be a party or with which he or she shall be threatened by reason of being or having been or acted on behalf of the Plan Administrator, except in relation to matters as to which he or she shall be adjudged in such action, suit, or proceeding to be liable for a breach of any fiduciary responsibility under ERISA. The foregoing right of indemnification shall be in addition to any other rights to which the Plan Administrator may be entitled as a matter of law.

7. CLAIMS AND APPEALS PROCEDURE

7.1 *Claims and Appeals Procedure Overview.* Participants or beneficiaries who disagree with a decision concerning their right to participate in the Plan or to receive reimbursement of Adoption Assistance Expenses, Dependent Care Expenses and/or Medical Expenses may file a claim in writing with the Plan Administrator. Claims and/or appeals of denied claims may be made by the Participant or the Participant's authorized representative (the "Claimant").

Claims and appeals relating solely to eligibility to participate in the Plan (including eligibility to make or change elections for a particular Qualified Benefit available under the Plan) are subject only to the Eligibility Claims and Appeal Procedure contained in Section 7.2 below. Claims and appeals relating in whole or in part to benefits claimed under the terms of the Plan are subject to the Claims and Appeals Procedures outlined in Sections 7.3 and 7.4 below.

7.1.1 *Compliance with the Patient Protection and Affordable Care Act (PPACA).* The plans governed by these claims procedures are excepted benefits that are not subject to the claims procedure requirements under the Patient Protection and Affordable Care Act (PPACA).

7.2 *Eligibility Claims and Appeals Procedure*. The following procedures apply if a Claimant is inquiring about eligibility to participate in the Plan (including eligibility to make or change elections for a particular Qualified Benefit available under the Plan). These rules do not apply if a Claimant is claiming the right to receive benefits under the Plan, rather than just inquiring about eligibility to participate.

Claimants who disagree with a decision concerning their right to participate or make or change elections in the Plan may file a claim in writing with the Plan Administrator. The Plan Administrator will review the claim and generally will notify the Claimant of its decision within ninety (90) days after it receives the claim. However, if the Plan Administrator determines that special circumstances require an extension of time to decide the claim, it may obtain an additional ninety (90) days to decide the claim. Before obtaining this extension, the Plan Administrator will notify the Claimant, in writing and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

If an eligibility claim is denied in whole or in part, the Plan Administrator shall provide a written notice within the time period described above, setting forth: (i) the specific reasons for the denial; (ii) specific reference to the provision of this Plan upon which the denial is based; (iii) any additional material or information the Claimant should furnish to perfect the claim and an explanation of why such material or information is necessary; (iv) the Claimant's right to receive, upon request and free of charge, reasonable access to and copies of all documents and information relevant to the claim; and (v) a description of the Plan's internal review procedures, information regarding how to file an appeal, and the time limits applicable to such procedures, including the Claimant's right to file a civil action following an adverse benefit determination on review. The notice will be written in a manner calculated to be understood by the claimant.

Claimants who disagree with the decision reached by the Plan Administrator may submit a written appeal within sixty (60) days of receiving the initial adverse decision. The written appeal should clearly state the reason or reasons why the Claimant disagrees with the Plan Administrator's decision. The Claimant may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, the Claimant may have reasonable access to and copies of all Plan documents, records and other information relevant to the claim.

The Plan Administrator will review the appeal and will generally issue a written decision within sixty (60) days of its receipt. If special circumstances require an extension of time for reviewing the claim, the Claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Plan Administrator will decide the appeal, which date will be no later than sixty (60) days from the end of the first 60-day period.

Once the Plan Administrator has made a decision, the Claimant will receive written notification of the decision. In the case of an adverse decision, the notice will: (i) explain the reason or reasons for the decision; (ii) include specific references to Plan provisions upon which the decision is based; and (iii) indicate that the Claimant is entitled to, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim. The notice will also include a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and a statement of the Claimant's right to bring an action under ERISA.

7.3 *Benefits Claims Procedure*. Claims for benefits under any policy of Dental Insurance, Disability Insurance, Health Insurance, Life Insurance, or Vision Insurance purchased with premiums paid under this Plan, or for benefits from a Health Savings Account, shall be made according to the procedures established in the written policy or program established by the respective third-party carrier or trustee/custodian.

Claims for Adoption Assistance Expense, Dependent Care Expense and/or Medical FSA expense Qualified Benefits shall be paid in accordance with the terms of the Plan. Claims for Adoption Assistance Expense, Dependent Care Expense and/or Medical FSA expense Qualified Benefits shall be made to the Service Provider on a form provided by the Service Provider, provided that if a Beniversal Card is used to pay an expense that is electronically validated at the point-of-sale to be an eligible expense, in accordance with the rules and procedures set forth in Section 4.5. Each claim form must be accompanied by such documentation or certifications as may be required in accordance with Section 4.5 and must be received by the Service Provider within the timeframe indicated in the Plan Highlights.

The Service Provider or Plan Administrator, in its sole and complete discretion, will decide if a

claim should be reimbursed. If any part of a claim for Medical Expenses under Medical FSA is denied, absent any necessary extension, the Service Provider shall provide a written notice as soon as possible, but in no event more than thirty (30) days after the receipt of the claim by the Service Provider, setting forth: (i) the specific reasons for the denial; (ii) sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (iii) specific reference to the provision of this Plan upon which the denial is based; (iv) any additional material or information the Claimant should furnish to perfect the claim and an explanation of why such material or information is necessary; (v) the Claimant's right to receive, upon request and free of charge, reasonable access to and copies of all documents and information relevant to the claim; (vi) a description of the Plan's review procedures, information regarding how to file an appeal, and the time limits applicable to such procedures, including the Claimant's right to file a civil action following an adverse benefit determination on review; (vii) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy will be provided free of charge to the Claimant upon request; (viii) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice shall also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (ix) the identity of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination. The notice will be written in a manner calculated to be understood by the Claimant.

If special circumstances beyond the control of the Plan require it, the Service Provider may extend the time for deciding a Medical FSA Medical Expense claim for up to an additional fifteen (15) days by providing written notice of such extension to the Claimant. If the extra time is needed because the Claimant has not provided information needed to decide the claim, the notice will also describe the needed information and the Claimant will have forty-five (45) days to provide the needed information. If the Claimant provides additional information in response to such a request, a decision will be rendered within fifteen (15) days of when the information is received.

If any part of a claim for Adoption Expenses or Dependent Care Expenses is denied, absent special circumstances requiring an extension of time, the Service Provider shall provide a written notice, within ninety (90) days after the receipt of the claim by the Service Provider, setting forth the aforementioned items (i) through (vii) unless extra time is needed to decide the claim. If extra time is needed, the ninety (90) day period may be extended by an additional ninety (90) days (for a total of one-hundred eighty (180) days), and the Claimant will be notified in writing during the initial ninety (90) day period of the special circumstances requiring an extension and the date by which the Service Provider expects to render a decision.

7.4 *Benefits Claims Review Procedure*. Review of any adverse benefit determination under any policy of Dental Insurance, Disability Insurance, Health Insurance, Life Insurance, or Vision Insurance purchased with premiums paid under this Plan, shall be made according to the procedures established in the written policy or program established by the respective third-party carrier. Claimants who disagree with a decision concerning their right to participate in the Plan or to receive Qualified Benefits may file an appeal in writing with the Plan Administrator.

If a claim for Medical Expenses under a Medical FSA is denied and a review is desired, the Claimant shall have one-hundred eighty (180) days after receipt of written notice of denial in which to notify the Plan Administrator in writing. If a claim for Adoption Expenses or Dependent Care Expenses is denied and a review is desired, the Claimant shall have sixty (60) days after

receipt of written notice of denial in which to notify the Plan Administrator in writing.

In requesting a review, the Claimant may review this Plan or any documents relating to it and submit any written comments, documents, records and other information the Claimant may feel appropriate, without regard to whether such information was submitted or considered in the initial benefit determination made by the Service Provider. The Claimant may obtain, free of charge and upon request, records and other information relevant to the claim, without regard to whether such information was relied upon by the Service Provider in making the initial benefit determination.

The Plan Administrator shall review an appeal for Medical FSA Medical Expenses and provide a written decision within sixty (60) days. The review shall not afford deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual. If a Claimant's Medical FSA Medical Expense appeal is denied and the denial was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional with training and experience in the relevant medical field. This health care professional will not have been involved in the original denial decision, nor be supervised by the health care professional involved in the initial decision. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be identified in the written appeal response, without regard to whether the advice was relied upon in making the benefit determination.

The Plan Administrator shall review an appeal for Adoption Expenses or Dependent Care Expenses and provide a written decision within sixty (60) days, unless extra time is needed to review the claim. If extra time is needed, the sixty (60) day period may be extended by an additional sixty (60) days (for a total of one-hundred twenty (120) days) and the Claimant shall be notified in writing within the initial sixty (60) day period of the special circumstances requiring an extension and the date by which the Plan Administrator expects to render a decision. If extra time is needed because the Claimant has not provided information needed to review the claim, and if the Claimant provides additional information in response to such a request, a decision will be rendered within sixty (60) days of when the information is received.

If during the pendency of the claim or appeal the Plan obtains any new or additional evidence that is considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, the Plan will provide the Claimant with the new or additional evidence at no cost as soon as possible and sufficiently in advance of the date when the Plan must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

Additionally, before the Plan denies such a claim on appeal in whole or part based on a new or additional rationale, the Plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently in advance of the date when the Plan Administrator must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

The Plan Administrator's written decision shall set forth the same elements required for the written notice of claim denial in Section 7.3 above. In addition, the written decision on appeal will also include a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, a statement of the member's rights to bring a civil action under section 502(a) of ERISA.

8. AMENDMENT AND TERMINATION OF THE PLAN

8.1 *Amendment.* The Employer may amend the Plan at any time or from time to time by an instrument in writing executed with the same formality as this instrument. Any amendment shall

be effective only for periods after the later of its adoption date or effective date. However, no amendment shall affect the rights of Participants with respect to the payment of Qualified Benefits incurred prior to the effective date of the amendment.

8.2 *Termination.* The Plan is intended by the Employer to be an indefinite program for the provision of Qualified Benefits for its Employees. The Employer nevertheless reserves the right to terminate the Plan at any time and for any reason. Such termination shall be effected by a written instrument executed by the Employer with the same formality as this instrument. Termination of the Plan shall not affect the rights of Participants with respect to the payment of Qualified Benefits incurred prior to the effective date of termination.

9. MISCELLANEOUS

9.1 *No Employment Rights Conferred.* The adoption and maintenance of the Plan shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration for, or an inducement to or condition of, the employment of any person.

Nothing herein contained shall be deemed to: (i) give to any Participant the right to be retained in the employment of the Employer; (ii) interfere with the right of the Employer to discharge any Participant at any time; (iii) give to the Employer the right to require any Participant to remain in its employment; or (iv) interfere with any Participant's right to terminate employment with the Employer at any time.

9.2 *No Compensation for Other Purposes*. Qualified Benefits paid under the terms of this Plan shall not be treated as additional compensation to the Participant for purposes of determining contributions or benefits under any qualified retirement plan maintained by the Employer or for purposes of any other benefit obligations of the Employer unless otherwise provided under the terms of the retirement plan or other benefit program.

9.3 *General Assets*. Payment of Qualified Benefits shall be made out of the assets of the Employer generally available for payment of its obligations. There shall be no special trust fund for payment of Qualified Benefits. Except as provided in a qualified medical child support order (within the meaning of Section 609(a) of ERISA), and except to the extent that this provision may be contrary to other law, Qualified Benefits payable from the Plan shall not be subject to assignment or transfer or otherwise alienable, either by voluntary or involuntary act of a Participant or by operation of law, nor subject to attachment, execution, garnishment, or other seizure under any legal or equitable process.

9.4 *Impossibility of Performance.* In the event that it becomes impossible for the Employer to perform any act under the Plan, that act shall be performed which in the judgment of the Employer shall most nearly carry out the intent and purposes of the Plan.

9.5 *Governing Law.* All legal questions pertaining to the Plan shall be determined in accordance with the laws of the Plan Administrator's State except when those laws are preempted by the laws of the United States.

9.6 *Code and Legal Requirements.* The Plan is intended and shall be interpreted to comply with all applicable laws and regulations, including all applicable Code requirements. Such requirements are incorporated by reference to the extent required and not expressly set forth herein and to the extent any provision of the Plan conflicts with applicable legal requirements, shall be reformed to effect compliance.

9.7 *Special Relief Provisions that Employers Can Elect under IRS Notice 2020-29.* IRS Notice 2020-29 permits Employers to elect certain temporary relief provisions. Specifically, to the extent elected by the Employer, the following rules apply and shall supersede any Plan provision

to the contrary:

- During the 2020 calendar year and subject to such limitations that are specified by the Employer, a Participant may on a prospective basis revoke an election, make a new election, or decrease or increase an existing election regarding the Participant's Medical Flexible Spending Account. Any change allowed shall not permit a revocation or decrease in election below the amount already reimbursed.

- During the 2020 calendar year and subject to such limitations that are specified by the Employer, a Participant may on a prospective basis revoke an election, make a new election, or decrease or increase an existing election regarding the Participant's Dependent Care Flexible Spending Account.

- During the 2020 calendar year and subject to such limitations that are specified by the Employer, a Participant may on a prospective basis (i) make a new election for Employer-sponsored Health Insurance, Dental Insurance, and/or Vision Insurance if the Participant initially declined to elect such employer-sponsored coverage; (ii) revoke an existing election for Employer-sponsored Health Insurance, Dental Insurance, and/or Vision Insurance and make a new election to enroll in different Employer-sponsored Health Insurance, Dental Insurance, and/or Vision Insurance (including changing enrollment from self-only coverage to family coverage); or (iii) revoke an existing election for Employer-sponsored Health Insurance, Dental Insurance, and/or Vision Insurance, provided that the Participant attests in writing that the Participant is enrolled, or immediately will enroll, in other health coverage not sponsored by the Employer.

- Subject to such limitations that are specified by the Employer, a Participant may apply unused amounts remaining in the Participant's Medical Flexible Spending Account or Dependent Care Flexible Spending Account as of the end of a grace period ending in 2020 or the Plan Year ending in 2020 to pay or reimburse expenses incurred for the same qualified benefit through December 31, 2020.

The above provisions are qualified by, and subject to, the requirements of IRS Notice 2020-29.

9.8 *Special Claims Rules Adopted in Connection with COVID-19.* The Internal Revenue Service and Employee Benefits Security Administration issued a joint rule in May 2020 extending the timeframes under ERISA and the Internal Revenue Code for making certain benefits-related elections, as further amended and clarified by EBSA Disaster Relief Notice 2021-01 and other guidance (collectively, the "Joint Notice"). To the extent required by the Joint Rule, certain periods beginning from March 1, 2020 until 60 days after the end of the National Emergency Concerning the Novel Coronavirus Disease (subject to a 12-month maximum period), will be disregarded in determining the following periods and dates:

- The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Code section 9801(f);

- The 60-day election period for COBRA continuation coverage under ERISA section 605 and Code section 4980B(f)(5);

- The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Code section 4980B(f)(2)(B)(iii) and (C);

- The date for Participants to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Code section 4980B(f)(6)(C);

- The date within which Participants may file a benefit claim under the Plan's claims procedures; and

- The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedure.

The above rules only apply to the portions of the Plan that are subject to ERISA (e.g., the special rules do not apply to Dependent Care Flexible Spending Accounts).

9.9 *Special Relief Provisions that Employers Can Elect under the Consolidated Appropriations Act, 2021.* Under the Consolidated Appropriations Act, 2021 (the "CAA"), Employers may elect certain temporary relief provisions. Specifically, to the extent elected by the Employer, the following rules apply and shall supersede any Plan provision to the contrary:

- Subject to such limitations that are specified by the Employer, for Plan Years ending in 2020, Participants may be permitted to carry over (under rules similar to the rules applicable to the Medical Flexible Spending Account) any unused benefits or contributions remaining in the Participant's Medical Flexible Spending Account or Dependent Care Flexible Spending Account from such Plan Year to the Plan Year ending in 2021.

- Subject to such limitations that are specified by the Employer, for Plan Years ending in 2021, Participants may be permitted to carry over (under rules similar to the rules applicable to the Medical Flexible Spending Account) any unused benefits or contributions remaining in the Participant's Medical Flexible Spending Account or Dependent Care Flexible Spending Account from such Plan Year to the Plan Year ending in 2022.

- Subject to such limitations that are specified by the Employer, the Employer may extend the grace period for a Plan Year ending in 2020 or 2021 to 12 months after the end of such Plan Year with respect to unused benefits or contributions remaining in a Participant's Medical Flexible Spending Account or Dependent Care Flexible Spending Account.

- Subject to such limitations that are specified by the Employer, the Employer may permit an employee who ceases to participate in the Plan during calendar years 2020 or 2021 to continue to receive reimbursements from his Medical Flexible Spending Account (under rules similar to the rules applicable to the Dependent Care Spending Account) of unused benefits or contributions through the end of the Plan Year in which such participation ceased (including any grace period).

- For purposes of determining eligible reimbursements from a Participant's Dependent Care Spending Account, in the case of a Participant who qualifies as an "Eligible Employee" (as defined below), a Dependent Care Expense shall be determined by substituting "age 14" for "age 13" in Code Section 21(b)(1)(B) for the "First Plan Year" (as defined below) and, for a "Participant with Unused DCAP" (as defined below), the

Second Plan Year.

A "Participant with Unused DCAP" may only take advantage of this rule in the Second Plan Year to the extent of amounts paid for dependent care assistance for a dependent who attains age 13 in the First Plan Year or the Second Plan Year and only to the extent of the Participant's unused Dependent Care Flexible Spending Account balance for the First Plan Year.

- "Eligible Employee" means a Participant who (i) is enrolled in a Dependent Care Flexible Spending Account for the "First Plan Year" (as defined below); and (ii) has one or more dependents (as defined in Code Section 152(a)(1)) who attain the age of 13 during the First Plan Year; or, in the case of a "Participant with Unused DCAP" (as defined below), the subsequent Plan Year.

- The "First Plan Year" means the last Plan Year with respect to which the end of the regular enrollment period for such Plan Year was on or before January 31, 2020.

- The "Second Plan Year" means the Plan Year following the First Plan Year.

- "Participant with Unused DCAP" means a Participant who has an unused Dependent Care Flexible Spending Account balance for the First Plan Year.

This Dependent Care Spending Account change shall apply unless the Employer elects otherwise.

- For Plan Years ending in 2021 and subject to such limitations that are specified by the Employer, a Participant may make an election to modify prospectively the amount of such Participant's contributions to the Participant's Dependent Care Flexible Spending Account or Medical Flexible Spending Account (subject to applicable dollar limitations). Any change allowed shall not permit a revocation or decrease in election below the amount already reimbursed.

The above provisions are qualified by, and subject to, the requirements of the CAA.

9.10 *CARES Act Changes.* Notwithstanding any other provisions in the Plan to the contrary, medicines or drugs that are sold lawfully without a prescription need not be prescribed to qualify as Medical Expense reimbursable under the Plan's General Medical Flexible Spending Account or Limited Medical Flexible Spending Account if the expenses for these items are incurred after December 31, 2019. In addition, expenses for menstrual care products incurred by a Participant or his or her Spouse or Dependents after December 31, 2019, shall qualify as Medical Expenses reimbursable under the Plan's General Medical Flexible Spending Account or Limited Medical Flexible Spending Account.

9.11 *Contribution/Carryover Limits*. Subject to such additional limits that an Employer may impose, contributions and carryovers are subject to all applicable statutory limits.

APPENDIX A

A. Use and Disclosure of Protected Health Information (PHI)

The Plan will use and/or disclose Protected Health Information ("PHI") to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto ("HIPAA"), which are hereby incorporated by reference. For example, the Plan may use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The following terms are defined for purposes of this subsection:

Protected Health Information ("PHI") is individually identifiable health information, whether oral or recorded in any form or medium, which is collected from an individual, and which:

- Is created or received by the Plan;
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
  a. That identifies the individual; or
  b. With respect to which there is a reasonable basis to believe that the information can be used to identify the individual; and
- Is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. PHI excludes information in education records covered by the Family Educational Right and Privacy Act, records described at 20 U.S.C. § 1232(g)(a)(4)(B)(iv), and employment records held by the Plan Sponsor in its role as employer.

Electronic Protected Health Information ("e-PHI") is PHI that is transmitted by electronic media or maintained in any electronic medium.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and the referral of a patient for health care from one health care provider to another.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for the coverage and provision of plan benefits or to obtain or provide reimbursement for the provision of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Risk adjusting amounts due based on enrollee health status (not including genetic information) and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review; and,
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan).

Health Care Operations include, but are not limited to the following activities:

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities that do not involve consideration of genetic information relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to:
    a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or,
    b. Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- Resolution of internal grievances;
- The sale, transfer, merger, or consolidation of all or part of the "covered entity" within the meaning of HIPAA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- Consistent with the applicable requirements of the regulations issued under HIPAA, creating de-identified health information or a limited data set and fundraising for the benefit of the "covered entity" within the meaning of HIPAA.

Summary Health Information is information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 C.F.R. §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Unsecured PHI is PHI that is not secured through the use of technology or methodology specified by the Secretary of Health and Human Services ("HHS").

B. The Plan Will Use and Disclose PHI Consistent with HIPAA's Requirements and as Permitted by Authorization of the Plan Participant or Beneficiary

The Plan will use and disclose PHI consistent with the rules and requirements under HIPAA. To the extent required by HIPAA, the Plan shall obtain a written authorization from the individual who is the subject of the PHI for certain uses and disclosures of PHI.

C. Disclosures to the Plan Sponsor

The Plan will not disclose PHI to the Plan Sponsor unless it receives a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in Sections D and E below. Notwithstanding the foregoing, the Plan may disclose to the Plan Sponsor the following:

1. The Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of :
    a. Obtaining premium bids from health plans for providing health insurance coverage under the group health plan; or
    b. Modifying, amending, or terminating the group health plan.
2. The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the group health plan, or is enrolled in or has disenrolled from a particular coverage option offered by the Plan.

D. Plan Sponsor Covenants Regarding PHI

The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor through a written contractual agreement in accordance with 45 CFR § 164.314;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- Not use or disclose PHI genetic information for underwriting purposes;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware, including breaches of Unsecured PHI as required by 45 CFR § 164.410, and any other Security Incident of which becomes aware;
- Make PHI available in paper and/or electronic format to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and

- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. With Respect to e-PHI, the Plan Sponsor Agrees to the Following Conditions

The Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that it creates, receives, maintains, or transmits on behalf of the Plan, in accordance with HIPAA security rules;
- Ensure that the adequate separation between the Plan and Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information as part of its written contractual agreement in accordance with 45 CFR § 164.314;
- Report to the Plan any Security Incident of which it becomes aware. For purposes of this section, Security Incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI, as well as any probable compromise of Unsecured PHI of which it becomes aware; and
- Upon request from the Plan, Plan Sponsor agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to Plan Sponsor.

Notwithstanding the foregoing, these limitations shall not apply to Enrollment, Disenrollment, and Summary Health Information provided to Plan Sponsor pursuant to 45 CFR § 164.504(f)(l)(ii) or (iii); of e-PHI released pursuant to an Authorization that complies with 45 CFR § 164.508; or in other circumstances as permitted by the HIPAA regulations.

F. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

The Plan Sponsor shall permit only those individuals listed below to have access to PHI in order to carry out their duties with respect to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. In the event that the individuals listed below do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Plan Sponsor will ensure that the adequate separation between the Plan and Plan Sponsor is supported by reasonable and appropriate security measures.

The following employees, classes of employees or other persons under the Plan Sponsor's control (or acting on behalf of Plan Sponsor) may have access to PHI:

[Insert in the blanks below the title and/or description of the class of all person(s) expected to have access to PHI]

_____

_____

_____

G. Limitations of PHI Access and Disclosure

The persons described in Section F may only have access to and use and disclose PHI to the extent necessary to perform plan administration functions that the Plan Sponsor performs for the Plan.

H. Noncompliance Issues

If the persons described in Section F do not comply with HIPAA's and the Plan's privacy rules, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

I. Participant Notice

The Plan shall be operated in accordance with the Notice of Privacy Practices, written in accordance with 45 CFR § 164.502, which shall be distributed to Plan Participants and which may be amended from time to time by the Plan Administrator or insurer providing benefits.

J. Health Plan Policies and Procedures

In addition to the policies and procedures set forth in the Participant Notice, the Plan has established the policies and procedures to safeguard the privacy of PHI and comply with HIPAA's requirements. The Plan Administrator may amend such policies and procedures from time to time, as it deems appropriate.

K. Policy and Procedure for Notification of Breach of Unsecured Protected Health Information

The Plan and its contractors will strive to prevent breaches of Unsecured PHI electronically or otherwise, and maintain privacy and security measures to protect the confidentiality of PHI. Pursuant to HIPAA and Regulations promulgated thereunder, and the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the Plan will notify individuals if there is a probable compromise of Unsecured PHI.

Background and Purpose:

Pursuant to HIPAA and Regulations promulgated thereunder, and the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the Plan will notify individuals when Unsecured PHI has been acquired, accessed, used or disclosed by an unauthorized person, when a confirmed breach of the security of the system does not fall within a statutory exception or there is a low probability that the PHI has been compromised.

Policy:

Confirmed breaches of the security or privacy of Unsecured PHI will invoke certain actions to determine the probability that the PHI has been compromised based on a risk assessment and, under specific circumstances, notification of the breach will be made to the affected individual(s).

Procedure for Notification:

a. The Plan has implemented reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of PHI and PI in its possession.
b. The Plan has implemented reasonable systems for the discovery and reporting of a breach of PHI or PI. A "breach" of PHI is the unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of the PHI.
c. When a breach has been reported, an investigation into the breach will be conducted.

d. The investigation and steps taken will be thoroughly documented. If the conclusion of the investigation is that no breach occurred, no further action is necessary, but the investigation and conclusion will be thoroughly documented.

e. If it is confirmed that a breach of security or confidentiality has occurred and has resulted in the unauthorized disclosure of PHI, the following risk assessment steps will be taken:

    1. Determine whether or not the information breached was Unsecured. Unsecured PHI includes information not secured through encryption or destruction, and is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary of HHS in guidance issued under Section 13402(h)(2) of Public Law 111-5.
    2. Determine the reasonable likelihood that such information was accessed by an unauthorized person.
    3. Determine the probability that the PHI has been compromised based on a risk assessment of at least the following factors: (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated.

f. The risk assessment will be documented thoroughly, including the actions taken, the conclusions of the assessment and the basis for the determination that there was or was not a low probability that the PHI was compromised.

g. If it is determined that the information breached was secured and there is no reasonable likelihood that the secured information was rendered usable, readable or viewable by an unauthorized person, no further action is necessary, but the determination and conclusion will be documented.

h. If it is determined that the information breached was Unsecured, but the circumstance of the breach falls within one of the exceptions to HIPAA (45 CFR § 164.402) so notification is not required, such determination will be documented.

i. If it is determined that the breach of the security of the system demonstrates that there is more than a low probability that the PHI was compromised, the Plan will as soon as possible, but no later than sixty (60) days after the discovery of the breach, notify the individual(s) whose information was disclosed as a result of the breach and the determination and conclusion will be documented.

j. If it is determined that the information breached was Unsecured and notification is required, an analysis of the requirements for notification of the State in which the individuals reside will be conducted and documented.

k. If notification to law enforcement or another regulatory body or agency is required under State law such notification will be made to the regulatory body or agency in accordance with State law.

l. If State law requires notification to the individual, notification will be made in accordance with State law.

m. Notification to the individual may be delayed if a law enforcement agency determines that the notification will impede a criminal investigation and the notification will be made after law enforcement determines it will not compromise its investigation.

n. Notification of a breach to affected individuals will be in plain language and include at a minimum:

    1. A brief description of what happened, including the date of the breach and discovery of the breach; a description of the type of Unsecured PHI or other personal information that was involved in the breach;
    2. Any steps individuals should take to protect themselves from potential harm resulting from the breach;
    3. A description of the investigation into the breach, mitigation of harm to individuals, and protection against further breaches; and

4. Contact procedures, which will include a toll-free telephone number, an e-mail address, website or postal address.

o. The notification must include any additional information required by applicable State law.

p. If the breach involves more than 500 residents of a state or jurisdiction, notice will be provided to the media and to the Secretary of the Department of Health and Human Services contemporaneously.

q. A log of any and all breaches of Unsecured PHI of less than 500 individuals will be maintained and reported to the Secretary of HHS on an annual basis.

r. Business Associates and vendors, through their contracts and/or Business Associate Agreements with the Plan will be required to provide notification of a breach to the Plan so that affected individuals can be notified, as necessary. Business Associates must provide all available information without delay.

s. Documentation will be maintained of each individual notified, each notification provided to HHS and any other notification to the Secretary of HHS as required by law.

RECORD OF ADOPTION

By signing this Record of Adoption, the Employer approves and adopts the terms of the Flexible Benefit Plan as stated in the Plan Document and Plan Highlights. A copy of the current Plan Highlights is attached to this Plan and Record of Adoption and incorporated herein by reference.

_____ _____

(Date) *(Name)*

_____

(Title)