PLAN DOCUMENT
For the
CAFETERIA PLAN, and ACCOUNT PLANS

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Article II: Purpose

2.01 **Adoption and Purpose.** The Employer adopts this Cafeteria Plan under the terms and conditions set forth in this Plan Document as well as through the Enrollment Materials that are expressly incorporated by reference into this Plan Document. The plan allows Participants to elect between cash compensation or certain nontaxable Qualified Benefits Plans maintained by the Employer as identified in the Enrollment Materials. The Employer intends that this plan qualify as a Cafeteria Plan under Section 125 of the Internal Revenue Code. If any term in this Plan Document is found to be in conflict with federal or state law, the term will automatically be amended to comply with the federal or state law. Neither the Employer nor its designated representatives makes any commitment or guarantee that any amounts elected or paid for the benefit of a Participant will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant.

2.02 **Plan Detail and Demographics.** This Plan Document expressly incorporates by reference the following demographics from the Summary Plan Description: The Plan Name; the Plan Sponsor's name and address; the Plan Administrator's name and address, and the Plan Year.

Article III: Definitions

3.01 **Change in Status Event.** A Change in Status Event allows a Participant to revoke or change his/her pre-tax election during the Plan Year, and outside of the scheduled open enrollment period. The Employer allows all of the Change in Status Events published by the IRS for this type of plan under 26 CFR 1.125-4, as amended. A Participant who becomes eligible under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") for coverage under an accident or health benefit offered by the Employer will be allowed to make a consistent election, or election changes under this Cafeteria Plan.

Additional 'Change in Status' Event Election Change for Group Health Plan Coverage. Effective January 1, 2023, provided that the conditions set forth below are satisfied, this election change provision permits You to prospectively revoke Your election for family coverage under Your Employer's group health insurance plan in order to allow one or more Related Individuals (as defined below) to enroll in a Qualified Health Plan through a Health Insurance Exchange ("Exchange") in the individual market ("Marketplace Coverage"). A "Related Individual" is any individual who is enrolled in the Employer provided group health insurance plan because of a relationship to You.

You may prospectively revoke an election of family coverage under Your Employer's group health insurance plan, provided the following conditions are satisfied:

(1) One or more Related Individuals are eligible for a special enrollment period to enroll in Marketplace Coverage pursuant to guidance issued by the Department of Health and Human Services (DHS) and any other applicable guidance, or one or more already-covered Related Individuals seeks to enroll in a Marketplace Coverage during the Exchange's annual open enrollment period; and

(2) The revocation of the election of coverage under Your Employer's group health insurance plan corresponds to the intended enrollment of the Related Individual(s) in Marketplace Coverage for new coverage that is to be effective beginning no later than the day immediately following the last day of the coverage that is being revoked pursuant to Your election pursuant to this Additional Change in Status Event.

If You do not enroll in Marketplace Coverage, You must elect self-only coverage (or family coverage including one or more already-covered Related Individual) under Your Employer's group health insurance plan.

When making a revocation election pursuant to this Additional Change in Status Event, You will be required to represent that You and/or Related Individual(s) have enrolled or intend to enroll in Marketplace Coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked in accordance with these Additional Change in Status Event provisions and Your Employer may rely on such representation.

3.02 **Code.** The Internal Revenue Code of 1986, as amended from time to time.

3.03 **Compensation.** All the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Internal Revenue Code.

3.04 **Dependent.** For the purpose of the tax advantages available under this plan, a Dependent is an individual who is a dependent of a Participant within the meaning of Section 152(a) of the Internal Revenue Code, and any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). For the purposes of the tax advantages available under Qualified Benefit Plans that provide accident and health benefits as defined under Sections 105 and 106 of the Code, a Dependent is determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof and includes any child (as defined in Code § 152(f)(1)) of the Participant who at the end of the taxable year has not attained age 27.

3.05 **Eligible Employee.** An Employee who is eligible to participate in the one or more Qualified Benefits Plans sponsored by the Employer, limited to an "Employee" as defined below in Section 3.06, who meets additional requirements defined in the Employer's Enrollment Materials and not including the following:

(a) Employees who are Non-Resident Aliens (within the meaning of Section 7701(b)(1)(B) of the Internal Revenue Code) who are deriving no earned income (within the meaning of Section 911(d)(2) of the Code) from the Employer which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code); and,

(b) Employees who are self-employed individuals (as described in Section 401(c) of the Internal Revenue Code) including sole proprietors, partners in a partnership, or more than 2% owners of subchapter "S" Corporations. This exclusion applies to the Spouse, children, parents, and grandparents under the Code Section 318 attribution rules.

If an Employee is not eligible to participate in this plan and allowed to participate under any Qualified Benefits Plan, then the Employee cost will be paid with taxable income, and the Compensation will not be reduced by the Employer.

3.06 **Employee.** An Employee is a person who is currently or hereafter employed by the Employer, or by any other Employer aggregated under Sections 414(b), (c), (m), (n), or (o) of the Internal Revenue Code and the regulations thereunder, including a leased Employee subject to Section 414(n) of the Code.

3.07 **Employer.** The Employer adopting this plan and any affiliate or subsidiary that, with the consent of the Employer becomes an Employer, by adopting the plan, or any successor business organization that assumes the obligations of the Employer.

3.08 **Enrollment Materials.** The Employer will provide written Enrollment Materials at each enrollment period and during the Plan Year for midyear enrollees. The Enrollment Materials will provide the specific process for enrollment in the Qualified Benefits Plans. The Enrollment Materials are expressly incorporated by reference into this Plan Document.

3.10 **Participant.** Any person who has been or is an Eligible Employee and who qualifies to participate and enrolls in a Qualified Benefits Plan.

3.11 **Plan Year.** Commencing on the first day of the Plan Year and each anniversary thereof, except that the first Plan Year may include a period of fewer than twelve (12) consecutive months.

3.12 **Qualified Benefits Plan.** Employer-sponsored plans that are allowed tax advantages under this plan pursuant to Section 125(f) of the Internal Revenue Code. The list of Qualified Plans available under this Cafeteria Plan is provided in the Enrollment Materials.

3.13 **Spouse.** Any individual who is legally married to a Participant under applicable state law.

Article IV: Administration

4.01 **Employer's Duties.** In addition to any rights, duties or powers specified in this Plan Document, the Employer will have the following rights, duties, and powers:

(a) to interpret the plan, to determine the amount, manner and time for payment of any benefits under

the plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the plan;

(b) to adopt and apply any rules or procedures to ensure the orderly and efficient administration of the plan, and from time to time, amend or supplement such rules and regulations;

(c) to determine the rights of any participant, Spouse, or Dependent to benefits under the Qualified Benefit Plans;

(d) to develop appellate and review procedures for any Participant, Spouse, or Dependent denied benefits under the plan;

(e) to maintain records, it may require in connection with the proper administration of the plan;

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

(g) to correct any defect, supply any omission, or reconcile any inconsistency in the plan in such a manner and to such extent as it shall be deemed expedient to administer the plan;

(h) to amend or terminate this plan.

4.02 Information to be Provided to Employer. The Employer, or any of its agents, will collect employment records of Participants under the plan. These records will include any information the Employer may need for the proper administration of the plan. A Participant will furnish the Employer the data the Employer reasonably requests to ensure the proper and efficient administration of the plan.

4.03 Interpreting Plan Terms. Any interpretation of any provision of this plan made in good faith by the Employer as to the terms of this plan is final and will be binding upon the parties.

4.04 Misstatements. Any misstatement or other mistake of fact will be corrected as soon as reasonably possible upon notification to the Employer and any adjustment or correction attributable to such misstatement or mistake of fact will be made by the Employer as he considers equitable and practicable.

4.05 Review Procedures. An Employee or his/ her authorized representative can appeal a decision made to deny enrollment in a Qualified Benefits Plan or a decision to disallow an election change by sending a written request for an appeal to the Employer within 60 days of the decision to deny enrollment or an election change. The appeal will be performed in a manner that does not afford deference to the initial determination and will be conducted by the Employer or designee. A Participant can request, free of charge, reasonable access to, and copies of, all documents and records relevant to the decision. Benefit appeals for denied claims are addressed in the Qualified Benefits Plan descriptions provided by the Employer.

4.06 Medical Child Support Orders. The Employer will adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which complies with federal or applicable state law, including 29 USC Sec. 1169 relating to Qualified Medical Child Support Orders (QMCSO), including any federal regulations or state laws relating to the same. On the date coverage is provided as directed by a QMCSO the Employee-parent will become eligible to participate in this plan in order to pay his/her share of the cost of the coverage on a pre-tax basis.

4.07 The Privacy Rule. Protected Health Information ("PHI") is defined as information that is created or received by the Employer which relates to the past, present, or future physical or mental health or condition of a Participant; or, the provision of healthcare to a Participant; or the past, present, or future payment for the provision of healthcare to a Participant; and that identifies the Participant. The test is whether there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

- **Access to PHI:** The Employer's access to PHI is restricted to the minimum information necessary to administer the Healthcare FSA. This includes obtaining Participant elections and reimbursements for payroll administration. The Employer has access to PHI submitted for claims reimbursement when that claim is on an appeal from an adverse decision. Only the Benefits Coordinator and Employees trained in the federal privacy rule will have access to the PHI.
- **Permitted and Required Uses and Disclosures of PHI by the Employer:** The Employer may use and disclose PHI for plan administration functions only as permitted and required by this Plan Document, or as required by law. The Employer will not use or disclose PHI for employment-related actions or in connection with any other Employee benefits plan. When necessary, the Benefits Coordinator will disclose the PHI to consultants

and experts as required by the Department of Labor for a full and fair review or to perform plan non-discrimination testing as required by law.

- **Complaints:** If a Participant has any complaints regarding the way in which the Employer has handled PHI said Participant may complain to the Benefits Coordinator. No response from the Benefits Coordinator is required. A copy of this complaint procedure shall be provided to the Participant upon request. The Benefits Coordinator will keep a copy of the complaint, applicable documentation, and disposition if any, for a period of 6 years from the end of the Plan Year in which the act occurred.
- **No Retaliation:** No Employee will intimidate, threaten, coerce, discriminate against, or take other retaliatory action against Participants for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under the federal Privacy Rule.
- **Firewall:** The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of the group health plan; and 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.

  Employer will do the following:

  (1) Ensure that any subcontractors or agents to receive PHI agree to the same restrictions described above,
  (2) report to the health plan any use or disclosure that is inconsistent with this Plan Document or the federal Privacy Rule,
  (3) make the PHI information accessible to the Participants,
  (4) allow Participants to amend their PHI,
  (5) provide an accounting of its disclosures of PHI as required by the Privacy Rule,
  (6) make its practices available to the Secretary of Health and Human Services for determining compliance, and
  (7) return and destroy all PHI when no longer needed, if feasible.

4.08 The Federal Security Rule. This rule is intended to bring the plan into compliance with the "HIPAA Security Rule" as published on February 20, 2003 by the United States Department of Health and Human Services (HHS), and amended, including the final Security Standards under the Health Insurance Portability and Accountability Act of 1996 and the HITECH Act (Health Information Technology for Economic and Clinical Health Act) of the 2009. The Electronic Media contemplated by the HIPAA Security Rule includes the following:

(a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission. In order to send and receive Protected Health Information ("PHI" as defined in the Plan Document) necessary for plan administration by Electronic Media, the Employer will implement reasonable and appropriate safeguards for electronic PHI created, received, maintained or transmitted to or by the Employer on behalf of the group health plan; ensure that electronic "firewalls" are in place to secure the electronic PHI; ensure that all agents and subcontractors with access to electronic PHI comply with the security requirements; Report to the group health plan any security incident of which it becomes aware.

Article V: Eligibility and Participation

5.01 Eligibility Requirements. Each Employee who enrolls in a Qualified Benefits Plan must be eligible to participate in this plan to receive the tax advantages made available under this plan. The eligibility requirements for this plan are set forth in the Enrollment Materials.

5.02 Re-employment of Former Employees. A Participant whose employment terminates and is subsequently re-employed within 30 days of his/her separation of service and within the same Plan Year will immediately

rejoin the plan with the same benefit elections. Should the Participant return within 30 days of his/her separation of service during the following Plan Year, the Participant will be allowed to change elections through the plan enrollment process. A Participant whose employment terminates and who is subsequently re-employed with more than 30 days separation of service will need to re-satisfy plan eligibility requirements to rejoin the plan. Any unused reimbursement benefits account balance prior to the initial separation of service date will be forfeited.

5.03 **Termination of Participation.** A Participant will automatically cease to be a Participant on the earliest of the following dates:

(a) the date on which this plan or any Qualified Benefits Plan is terminated by the Employer;
(b) the end of the Plan Year, unless the Participant enrolls in a Qualified Benefits Plan for the next Plan Year;
(c) the date on which the Participant fails to pay any required premium (including payment by salary reduction);
(d) when the Participant's employment is terminated the plan will terminate on the day of the termination or the day using the rule stated in the employer's enrollment materials or SPD.

5.04 **Family Medical Leave Act.** The Family & Medical Leave Act of 1993 (29 U.S.C. 2611) as amended, is referred to as FMLA. FMLA Leave will not be available to Employees for Plan Years in which the Employer has fewer than 50 Employees as counted in that Act. For Plan Years in which the Employer has 50 or more Employees, the Employer is required to make FMLA Leave available to Eligible Employees under circumstances that are prescribed by applicable federal law, including a period in which an Employee is off due to the FMLA shall be treated in accordance with the rules for a layoff or a leave of absence and provided to the extent required by the FMLA (e.g., the employer will continue to pay its share of the contribution to the extent the Participant opts to continue coverage). If the Employer is subject to the FMLA, a Participant may revoke or continue an election through the plan upon commencement of the FMLA Leave, whether such leave is paid or unpaid. This provision applies in addition to any other right to revoke and reelect benefits under the plan. Upon return from FMLA Leave, a Participant may be reinstated to all pre-leave elections.

5.05 **Uniformed Services Employment & Re-employment Rights Act (USERRA).** The Employer shall permit Participants to continue benefits elections as required under the Uniformed Services Employment & Reemployment Rights Act and shall provide such reinstatement rights as required by such law.

5.06 **Layoff, Leave of Absences, and Sabbaticals.** Continuation under the plan may occur in one of the following ways:

(a) In the case of a planned layoff, an Employee may be able to pre-fund a Qualified Benefits Plan through the end of the planned leave or the end of the Plan Year.
(b) During the period which the Employee is off and receiving a salary, the pre-tax deductions may continue. If the Employee is not receiving a salary, he/she may continue to fund his/her election with after-tax dollars while on leave. (Payment schedule to be agreed upon between the Employer and Employee prior to the commencement of the leave.)

Article VI: Elections

6.01 **Election Maximum Amounts.** The maximum election amounts for each Qualified Benefit Plan will be included in the Enrollment Materials and the literature available for each Qualified Benefits Plan.

6.02 **Failure to Elect.** A Participant failing to complete the enrollment process on or before the specified due date for the Plan Year, or a midyear enrollee during the Plan Year, shall be deemed to have elected to receive Compensation in cash.

6.03 **Effective Periods for Elections.** The election must be made by each Participant prior to the commencement of each Plan Year and shall be irrevocable for the Plan Year except as provided for in a Change in Status Event that would allow an election change.

6.04 **Non-Discrimination.** The plan is not intended to discriminate in favor of highly compensated individuals or key Employees as to eligibility to participate or contributions and benefits as required by the Code. The Employer may exclude or limit certain highly compensated individuals from participation in the plan, in the Employer's judgment, such actions serve to assure that the plan does not violate applicable non-discrimination rules. The Employer can make necessary adjustments to Employee contributions during the

Plan Year to assure that the plan passes the required discrimination tests.

Article VII: Contributions

7.01 **Employer Contributions.** The Employer will contribute out of its general assets the amounts necessary to meet its obligations under the plan. The Employer may provide additional contributions in the way of cash or spending credits that can be used for any Qualified Benefits Plan or used in a limited manner as defined by the Employer. The Enrollment Materials will include the amount of any Employer contribution, the rules defining how the Employer contributions can be used by the Participants, and any limitations on the use of Employer contributions. Employer contributions will continue to be provided while on approved FMLA Leave to the same extent provided to an Employee actively at work.

7.02 **Employee Salary Reductions.** The participant shall agree to reduce his/her Compensation from the Employer by such amounts as are necessary to provide for those Qualified Benefits Plans which the Participant has elected. No Participant shall have, by virtue of the plan, any interest in any specific asset or assets of the Employer. A Participant has only an unsecured contractual right to receive the benefits defined and limited by the Qualified Benefits Plans.

7.03 **Administrative Fees.** The Employer may charge the Employee reasonable cafeteria plan administrative fees.

7.04 **SIMPLE Section 125 Cafeteria Plan**. If the Employer intends to offer a SIMPLE Plan, as set forth in Code Section 125(j), under the Employer's Cafeteria Plan, then the Employer contributions are limited as follows;

a) Uniform Percentage Contribution Requirements: Employer must contribute to provide Qualified Benefits on behalf of each Qualified Employee, regardless of whether an Employee makes a salary contribution of their own. The Uniform Percentage Contribution method requires the Employer to contribute a uniform percentage (of at least two percent) of an Eligible Employee's compensation for the Plan Year.

b) Matching Contribution Requirements: Employer must contribute to provide Qualified Benefits on behalf of each Qualified Employee, regardless of whether an Employee makes a salary contribution of their own. The Matching Contribution method requires the Employer to make an annual contribution in an amount equal to the lesser of the following 2 options (select the lesser option): (1) 6% of each

Employee's Plan Year compensation, or (2) 2x the amount of salary reduction contributions from each Qualified Employee.

Article VIII: Account Plans

8.01 **Account Plan Availability.** The Employer will notify Accountholder in the Enrollment Materials if Account Plans are offered, and if included for the Plan Year the following terms apply.

8.02 **Forfeiture (Use-it-or-lose-it Rule).** An Accountholder forfeits any amount of his/her annual election that exceeds the reimbursement during any Plan Year. An Accountholder who terminates coverage during the Plan Year has a runout period in which to submit eligible claims. An Accountholder who is covered through the end of the Plan Year will have a runout period in which to submit eligible claims. The duration of these run out (the number of run out days will be provided in the Summary Plan Description) provided by the Employer. Upon such forfeiture, An Accountholder's accrual will be reduced to zero. Forfeited funds can be retained by the Employer, or at the discretion of the Employer, forfeitures of benefits under the plan can be reallocated to Accountholders in any reasonable manner that has no relation to prior claims history. Forfeitures of benefits also may be applied towards the cost of administering the plan. Forfeitures of benefits will become the sole property of the Employer.

8.03 **Accountholder Certification and Debit Card Use.** The Plan requires the Accountholder to certify that each expense submitted for reimbursement has actually been incurred and has not previously been reimbursed (i.e., there is no "double-dipping"), and reimbursement will not be sought from any other source, such as another health plan for medical tax advantaged account services. The Plan requires the Accountholder to certify that upon enrollment in a TASC Subscription Service that includes the use of a TASC Debit Card, for the immediate service year and any

service year thereafter, that the card will only be used for legitimate eligible expenses, limited to persons eligible for reimbursement. This Certification is printed on the back of the TASC Debit Card and reaffirmed each time the TASC Debit Card is used. The TASC Debit Card will be shut off and should not be used after the Accountholder's termination of employment, except for spending down MyCash that has been accumulated.

8.04 **Death of Accountholder**. In the event of the death of the Accountholder prior to the payment of any claims, payment will be made in the following priority:

a) Executor of the Estate of the deceased Accountholder,
b) Spouse, or,
c) Family member held responsible for payment of deceased's medical bills.

8.05 **Amounts Paid in Error**. Upon any benefits payment made in error, an Accountholder will be required to repay the Plan. The Employer may take reasonable steps to recoup such an amount, including reducing the amount of future benefits reimbursements by the amount paid in error.

8.06 **Grace Period.** The Summary Plan Description will indicate whether there is a Grace Period for any Account Plan. The Grace Period extends two - and one-half months after the last day of your Plan Year. The last day of the Grace Period is the fifteenth day of the third month following the end of the Plan Year. Services that are rendered after the last day of this Grace Period will not be considered for reimbursement under the prior Plan Year. An Accountholder must be enrolled through the end of the last day of the Plan Year in order for this Grace Period to apply. Services that qualify for reimbursement and are rendered during the Grace Period will be reimbursed using any balance in the prior Plan Year annual election first, and then reimbursed from any new Plan Year annual election. If an Accountholder terminates coverage for any reason prior to the end of the last day of the Plan Year, then the Accountholder may not submit any claims for services that were rendered after your date of termination.

8.07 **Healthcare Flexible Spending Account (FSA). (CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED)** This plan is intended to provide reimbursement for certain medical expenses incurred and not otherwise covered by insurance or by the Employer. The Employer intends that the plan qualify as an accident and health plan under Section 105 and 106 of the Internal Revenue Code, and that the nontaxable benefits provided under the plan be eligible for exclusion from an Accountholder's incomes under Section 105(b) of the Code. The Healthcare FSA is an Employer Sponsored Welfare Plan as defined by ERISA (Employee Retirement Income Security Act of 1974) and is subject to ERISA. The Employer will provide a Summary Plan Description within 90 days of enrollment or on request. The Summary Plan Description will identify the Plan Administrator for this plan.

Qualified Expenses. All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Accountholder, Accountholder's spouse, or dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under this Plan.

Benefits. Benefits are provided from the Employer's general assets. There are no segregated funds established for this plan. The amount of an Accountholder's annual election is available on each day of the Plan Year in which the Employee is an Accountholder. An Accountholder is entitled to benefits under the plan for a Plan Year in an amount that does not exceed an Accountholder's annual election, and Employer contributions, if any. The amount of an Accountholder's annual election will be uniformly available during the Plan Year.

Claims. Each claim will be substantiated by the submission of a third-party statement that shows that the claim is for a Qualified Benefits Expense, or by automated means that comply with guidelines established under IRS Rev. Rul. 2003-43. If claims are submitted electronically, an Accountholder will sign a certification upon Enrollment or acceptance of an electronic card that claims submitted under the card have not been reimbursed by any other insurance or self-insured plan, and that an Accountholder is not seeking reimbursement under any other insured or self-insured plan. Services purchased under a prefunded debit card can be automatically substantiated as allowed

under IRS Notice 2006-69, including claims that are automatically substantiated using the Inventory Information Approval System (IIAS), amounts that are a multiple of a health plan copayment (up to five multiple copayments).

Limited Coverage (Spouse covered under an HSA). Section 1201 of the Medicare Prescription Drug, Improvement & Modernization Act of 2003, added Section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning on or after December 31, 2003. In order to allow an Employee's Spouse to contribute to an HSA Account, an Employee is required to submit a written request to the Benefits Coordinator requesting "single" or "Parent and Child(ren)" enrollment in this Healthcare FSA. Qualified Expenses are limited to covered services or supplies provided to the Employee and Dependents that are not covered under the Spouse's HSA. No claims for family members covered under the HSA can be submitted under this plan.

Carryover. The Allowed Carryover Maximum, if any, will be communicated on the first page of the Summary Plan Description provided to each Eligible Employee at open enrollment or when a new or existing Employee becomes eligible for enrollment in the plan. The Carryover Maximum will be the lessor of the amount communicated in the Enrollment Communications or maximum allowed. The Allowed Carryover will be the lesser of the Allowed Carryover Maximum or the unused benefit balance at the end of the Runout Period. A Runout Period immediately follows the end of a Plan Year during which an Accountholder may request reimbursement of expenses incurred for qualified benefits during the Plan Year. The duration of any Runout Periods will be detailed in the Summary Plan Description provided by the Employer. The amount carried over has no effect on the ability to elect the maximum salary reduction allowed under the plan for the new Plan Year. If an Accountholder elects the maximum salary reduction allowed under the plan, then the amount carried over will be in addition to that election.

Military Cash Out Option. An Accountholder in the plan will receive a Qualified Reservist Distribution upon written request provided to the Employer. A Qualified Reservist Distribution means a distribution to an Accountholder of all or a portion of the balance in the employee's account under the plan, if:

(a) an Accountholder was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United State Code)) ordered or called to active duty for a period of 180 days or more, or for an indefinite period; and,

(b) the distribution is requested and made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the plan for the Plan Year in which an Accountholder received the order or call.

The balance that can be distributed is limited to the amount of an Accountholder's actual payroll deductions made as of the date of the request, less any amount that has already been disbursed for valid claims submitted.

COBRA Continuation Coverage. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, does not apply to any group health plan of the Employer for any calendar year if all employers maintaining the plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. An Accountholder eligible for COBRA continuation coverage under this plan, shall be allowed to continue to participate in the plan until the end of the Plan Year in which the qualifying event occurred, as long as such an Accountholder complies with the provisions set out in COBRA. An Accountholder is eligible for COBRA coverage only when the cost to continue to the end of the Plan Year exceeds the remaining benefit. The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Internal Revenue Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

8.08 Limited Purpose Healthcare Flexible Spending Account. (CHECK YOUR ENROLLMENT MATERIALS TO DET DETERMINE IF THIS ACCOUNT PLAN IS OFFERED) This is a Healthcare Flexible Spending Account intended to accommodate persons who are making contributions to a Health Savings Account (HSA) and enrolled in a high deductible health plan ("HDHP") option. Any Employee who contributes to an HSA and elects to participate in this Healthcare FSA will automatically be placed in a Limited Purpose Healthcare FSA. A Limited Purpose Healthcare FSA provides reimbursement only for Qualified Expenses not otherwise covered by insurance or by the Employer that are for dental and vision services, and if designated as a Limited Purpose Post-Deductible Healthcare FSA, may also include qualified medical services provided after the HDHP statutory annual deductible has been satisfied.

8.09 Limited Purpose Post-Deductible Healthcare FSA. **(CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED)** A Qualified Expense under a Limited Purpose Post-Deductible Healthcare FSA is the same as a Qualified Expense under the Limited Purpose Healthcare FSA. With

the Limited Purpose Post-Deductible Healthcare FSA, after the statutory annual HDHP deductible has been satisfied, Qualified Expenses that are not covered by the HDHP can be submitted and reimbursed. An Explanation of Benefits ("EOB") from the insurance carrier that administers the HDHP is required to be submitted. The EOB needs to show the statutory HDHP deductible has been satisfied and the portion of the expense that has been submitted for reimbursement under this plan was not applied to the HDHP deductible.

8.10 Non-Employer Sponsored Premium Account. **(CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED)** This plan is intended to comply with Section 125 of the Internal Revenue Code. The Healthcare Premium (NESP) Reimbursement Account is a tax advantaged plan established with the intent of providing tax free reimbursement for the premium paid by an Employee for an individual insurance, providing health and accident benefits as defined under Sections 105 and 106 of the Code. The individual insurance plan is owned by the Employee. This can include a plan provided through Employee owned insurance policy(ies) issued by an insurance company, or a contract(s) with a health maintenance organization or point of service organization. Coverage offered through the Marketplace, (a state or federal plan under the Affordable Care Act), does not qualify. The following individual plans can be covered under the Healthcare Premium (NESP) Reimbursement Account.

a) Health insurance or HMO coverage for health expenses
b) Dental insurance
c) Eye care insurance
d) Medicare premium
e) Medigap or Medicare Supplemental premium
f) Tricare premium
g) Accidental death and dismemberment insurance
h) Long-term or short-term disability insurance

The Healthcare Premium (NESP) Reimbursement Account is not subject to the Employee Retirement Income Security Act of 1974 (ERISA). The individual plans purchased by the Employees are not Employer-Sponsored Welfare Plans as defined by ERISA, and as such are not subject to ERISA.

8.11 Dependent Care Flexible Spending Account (FSA). (CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED) This plan is intended to provide reimbursement for certain Dependent Care Expenses incurred by an Accountholder. The Employer intends that the plan qualify as a dependent care assistance plan under Section 129(d) of the Internal Revenue Code, and that the nontaxable benefits provided under the plan be eligible for exclusion from an Accountholder's income under Section 129 of the Code. This plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Maximum Contribution. An Accountholder can defer the lesser of $5,000, their earned income, or the Spouse's earned income, per Plan Year. If a Spouse is disabled or a full-time student with no income, then the Spouse is deemed to have a monthly income of $250, if one dependent, $500 if two or more dependents. A married Accountholder who files a separate tax return is limited to $2,500 per year. Contributions to the plan are made and limited in accordance with an Accountholder's annual election.

Maximum Benefit. An Accountholder can never withdraw more funds than actually contributed on the date a claim is submitted. If an Accountholder fails to use his/her entire election at the end of the Plan Year or upon other termination of the plan, the unused election cannot be cashed out and becomes the property of the Employer.

Dependent Care Expenses. Expenses incurred by an Accountholder for the care of a Qualified Person or for related household services which would be considered employment-related expenses under Section 21(b)(2) of the Internal Revenue Code.

Qualifying Person. All child and Dependent Care Expenses must be for the care of one or more Qualified Persons. A Qualifying Person is defined as the following:

a) A child who is claimed as an Accountholder's Dependent and who was under the age of 13 when the care was provided;
b) An Accountholder' Spouse who was physically or mentally unable to care for himself/herself and lived with an Accountholder for more than half of the year;
c) A person who was physically or mentally unable to care for himself or herself and lived with an Accountholder for more than half of the year, and either of the following:
    1) Was an Accountholder's Dependent; or
    2) Would have been an Accountholder's Dependent without the occurrence of one of the following:

3) He or she received gross income equal to or in excess of the exemption amount for Dependents under Internal Revenue Code § 151(d);
4) He or she filed a joint tax return;
5) An Accountholder or an Accountholder's Spouse if filing jointly, could be claimed as a Dependent on someone else's federal tax return.

Child of divorced or separated parents. Even if an Accountholder cannot claim a child as a Dependent, he or she is treated as a Qualifying Person if one of the following applies.

a) The child was under the age of 13 or was physically or mentally unable to care for himself/herself; or
b) An Accountholder was the child's custodial parent (the parent with whom the child lived for the greater part of the calendar year), and the non-custodial parent is entitled to claim the child as a Dependent under the special rules for a child of divorced or separated parents. If this applies, the non-custodial parent cannot treat the child as a Qualifying Person.

Benefits and claims. Benefits are provided only for the reimbursement of a Qualified Person's Dependent Care Expenses that are incurred during the Plan year and during the period in which the Employee was an Accountholder. Benefits are limited to the amount that has actually been withheld from an Accountholder's Compensation on the date the claim is processed. Reimbursement will be made under the plan only on the basis of Dependent Care. To make the determination that a Dependent Care Expense subject to reimbursement has been incurred, proper evidence of any or all of the following may be required:

a) The name of the Qualified Person for whom the expenses have been incurred;
b) The nature of the services incurred;
c) The date the services were incurred;
d) The amount of the requested reimbursement; and,
e) That the expenses have not been otherwise paid through a program offered by the Employer or any other employer or reimbursed from any other source.